Maternal and Child Health Services
Title V Block Grant

State Narrative for South Carolina

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The signed assurances and certification forms are kept in the official grant file

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

During the past year the MCH block grant process for public comment has been linked to the development of the needs assessment. Focus/workgroups with participants that include agency partners, advocacy groups, regional public health staff, and parent/consumers have been given voice through targeted discussions centered around maternal and child health and children with special health care needs. These discussions defined service barriers and continued fragmentation of care for the children who are most fragile.

Obtaining quality public input during the development of the Title V block grant application during the interim needs assessment years remains a challenge. In the past, several venues for obtaining public input have been explored. Examples include scheduled public hearings, posting on agency web-site for comment, surveys, executive summaries, etc. These efforts have yielded limited success at best. The most meaningful mechanisms for obtaining public input have come through advisory committees: 1) The Commissioner's Pediatric Advisory Committee- pediatricians and family physicians advising policies impacting health and insurance, and 2) The Commissioner's Obstetric Task Force -- obstetricians, regional public health directors, and regional obstetric support services staff. Each of these committees meets quarterly where members offer timely feedback on policies and practices that must shift in concert with current changing landscape of federal and state dollars.

Following the submission of this year's application and corresponding needs assessment, MCH will take the results back to all stakeholders participating in the process. The 2010 needs assessment and an executive summary of block grant activities will be available via the agency's web-site and directly distributed to key partners. Results and future activities will also be discussed during advisory council meetings and feedback obtained as appropriate.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

Every five years the MCH Bureau conducts a comprehensive needs assessment to provide decision makers with the foundational information needed to engage in meaningful priority setting to guide program planning, implementation and evaluation and activities funded under Title V. To complete the assessment, MCH staff complied data and information using both quantitative and qualitative methods, conducted quasi-focus groups with providers to obtain perspective on health and health service needs, held key stakeholder meetings around each of the established MCHB population groups to review and discuss relevant data and information, conducted site visits to each of 8 DHEC public health regions to gain local perspective on needs and capacity, and utilized various components of CAST-V methodology to assess current capacity to perform core public health functions and essential services. MCH leadership compiled all available information stemming from the assessment process to establish priority areas of need and associated performance measures for the next five year planning cycle.

Priority needs and performance measures identified during the 2010 assessment process are largely reflective of the current capacity within the agency and MCH. Focus was placed on identifying needs and measures within the scope of existing program capacity. New priorities and performance measures reflect a fundamental need to re-build an eroded infrastructure, strengthen working relationships within and outside the MCH Bureau, and strategically position MCH to provide core public health functions within the evolving health care environment following the passage of health care reform.

The new priorities include:
1. Improve overall pre/inter-conception health status of South Carolina women (Infrastructure Building Service)
2. Reduce the annual rate of maternal deaths (Infrastructure Building Service)
3. Reduce the number of infant deaths due to SIDS/Unsafe sleep environments (Enabling/Population Based Servide)
4. Increase the knowledge of appropriate child social-emotional development among parents and early childhood service providers (Enabling Service)
5. Improve systems for obtaining parental involvement in the planning, implementation, and evaluation of DHEC programs and services for CSHCN (Infrastrucuture Buillding Service)
6. Promote and support regional based planning of MCH programs/initiatives (Infrastructure Building Service)
7. Increase the degree to which MCH is actively engaged in ongoing assessment and assurance activities (Infrastrucure Building Service)
8. Improve coordination of activities related to existing performance MCHB National Performance Measures with a focus on those outside of the MCH Bureau (Infrastructure Building)
9. Invest in building existing MCH workforce leadership competencies and skills related to data analysis and program evaluation (Infrastructure Building Service)

III. State Overview

A. Overview

Overall Health and Well-Being

Approximately 68% of the State is White, 28.5% African American, and 4.1% of Hispanic ethnicity. Nearly one quarter (23.8%) of the State's population is under the age of 18. South Carolina has a large rural contingency with 70% of the State residing in urban commuting areas, 20% in large rural areas, and 10% residing in small rural areas. As typical of the Southeastern United States, African Americans are disproportionately represented in small rural areas of the state placing them in a doubly disadvantaged position, and adding to the unique challenges for delivery of Title V services.

Pregnant Women, Mothers, and Infants-Improved birth outcomes remain a priority for South Carolina. The State has seen notable improvements in infant mortality rates over the past few years, particularly among African American infants. The 2008 infant mortality rate of 8.0 per 1,000 live births is among the lowest rate in 20 years. Moreover, the infant mortality rate among African American infants (11.4) has declined for 3 consecutive years and is the also at an all time low. Reductions in the proportion of very low birth weight outcomes among African American infants are a significant factor in the observed decrease in infant mortality rates. Although progress is being made, increasing obesity and chronic co-morbidities including hypertensive disorders and diabetes continue to adversely impact pregnancy outcomes. Deaths due to accidents, particularly accidental suffocation and co-sleeping, remains a significant issue impacting the health and well being of infants.

Children- Approximately one in five children and adolescents under the age of 19 live in homes currently under the federal poverty line, with values ranging from 14%-50% by county.
The general health status of South Carolina children seems to be consistent with the rest of the United States. According to 2007 National Survey of Children's Health (NSCH) data, 84.5% of parents report their children's health as excellent to very good; which is comparable to 84.4% among the nation. Also consistent with national data, approximately 9.2% of South Carolina children lack health insurance and 15.4% lacked consistent coverage during the year. Moreover, nearly one in every ten (9.7%) children have injuries that require medical attention and one of every four (26.5%) children between 4 months and five years are determined to be at moderate to high risk of developmental or behavioral problems. However, a much higher proportion of South Carolina children between 6-17 repeat a grade in school compared to the rest of the country (16.0% versus 10.6%).

CSHCN- Like all children that meet the AAP/MCHB definition of "children with special health care needs", many children in SC with chronic illnesses or disabling conditions have difficulty affording out-of-pocket expenses required to meet their child's health care needs. According to the 2007 National Survey of Children with Special Health Care Needs, 15.2% of South Carolina children (157,801) have special needs, compared to 13.9% among the nation. For the most part, key indicators for CSHCN in South Carolina are consistent with what is observed at the national level. Approximately 60% of South Carolina families partner in decision making at all levels and are satisfied with services received compared to 57.4% among the nation. The proportion of South Carolina parents reporting receiving comprehensive, ongoing, coordinated care in a medical home (53.1%) is slightly higher than 47.1% of parents across the country. The proportion of South Carolina parents reporting adequate public or private insurance to pay for needed health services (61.1%) is comparable to 62.0% of parents across the country.

Health Care Environment

The current state health care environment presents significant challenges and opportunities. The unemployment rate in South Carolina has reached 12.6% creating a significant increase in the

need for health services. The downturn in the national/state economy continues to create state fiscal challenges that translate to significant budget cuts. Declining state revenue coupled with an increased need for basic health services has challenged the healthcare environment.

As a primary source of insurance for women and children in SC, Medicaid policy is central to discussion of the state health care environment. Over the past year, Medicaid eligibility has seen significant expansion, with the largest increases among children. As the driving force in shaping this health care environment, Title V programs and activities are inseparably linked and must adjust along with Medicaid policies.

Pregnant Women, Mothers, and Infants- Approximately half of all pregnancies among South Carolina women remain unplanned. South Carolina is fortunate to have the Medicaid Family Planning waiver; however challanges in accessing contraceptive services remain due to barriers stemming from CMS and the Federal Deficit Reduction Act. Rising costs for contraceptives, particularly long-term methods, is an ongoing issue. The penetration of Medicaid Managed Care has also created challenges in accessing care for pregnant women. Clients are automatically enrolled into one of several managed care plans, each unique in what they provide, thus, fragmenting consistency of covered services.

Also impacting access to care in SC is legislation that requires health care providers to report to law enforcement any children under 16 that admit having sexual relations. Teens seeking family planning services as well as some young prenatal women have been adversely impacted. The Office of General Counsel and MCH have provided extensive training and resources to ensure staff report in accordance with the law. Simultaneously, they are working with advocacy agencies to promote legislation that will allow medical providers exemption from reports that are solely based upon age.

South Carolina continues to see reductions in the availability of obstetric care in areas of the state with vulnerable populations. In the past year, Allendale Hospital, a rural facility in an underserved area, discontinued obstetric services. In addition, North Central (FQHC) in York County stopped providing prenatal care services. The clinic saw an average of 900 patients annually, many of which were of Hispanic ethnicity. After extensive community advocacy, the clinic re-opened but with limited staffing. These examples illustrate how loss of care in an already underserved area creates significant barriers in obtaining needed prenatal services.

Children-As noted, Medicaid eligibility expansion among children has been substantial. With growing numbers of families seeking Medicaid coverage for their children, revenue to support Medicaid services remains an issue. Efforts to enroll children into MCO's to improve quality and reduce cost have left many families continuing to struggle with the enrollment process, expectations of the medical homes, and understanding of the systems of care. Lack of access to behavioral health and subspecialty medical providers remains an area of concern. SC DHHS is instituting a payment system for credentialed private behavioral health providers in the summer of 2010 to address these needs. MCH provides few direct services for children; however, shaping policy related to children's services is an ongoing MCH leadership role.

CSHCN-Medicaid policies are also instrumental in shaping program activities for CSHCN. Navigation of multiple health care systems has become increasingly difficult with expansion of managed care organizations. Although there are some core expectations of all MCO's, there is great variability in their individual policies and procedures pertaining to eligibility and prior approval for services. Pediatric sub specialists affiliated with the four hospitals in the SC Children's Hospital Collaborative serve as a network of providers available to CSHCN throughout the state. These providers, in addition to pediatric and/or family practices with effective medical homes, help assure availability of high quality services for all CSHCN in the state. However, financial and geographic accessibility remain an issue for families throughout this poor, rural state.

DHEC remains a major funding source for medical and related services for CSHCN with a range of medical conditions through the Children's Rehabilitative Services (CRS) program. Services are provided by approved physicians, pharmacies, and DME suppliers. Covered medical services are most frequently provided through the state's four children's hospitals and/or providers affiliated with these hospitals.

In January of 2010, the Governor transferred lead agency status for Idea Part C (BabyNet) from DHEC to South Carolina First Steps. DHEC remains under contract with First Steps to provide a set array of services; however, we are no longer responsible for the oversight and implementation of services to those from birth to 3 with developmental disabilities. Key MCH staff members devoted many hours of detailed work to assure a smooth transition of lead agency responsibilities. Remaining programs have shifted focus to provision of service coordination within a broader system of care. The need to maximize limited resources for the largest number for children continues to be a priority.

The passage of health care reform during the previous fiscal year will have a significant impact on current and future Title V programs and activities. The impact and ramifications of health care reform can vary by program and population; however, as access to health insurance (particularly for CSHCN) increases the role of public health and Title V will need to be examined to best align services with needs. DHEC Health Services created a policy review team to examine the details and assess potential implications for public health services. MCH has three representatives on this committee.

Agency Priorities and Title V

Agency priorities impacting Title V programming are reflected in the 2005-2010 DHEC Strategic Plan. Goal 2-C of the plan is to ‘Improve Maternal and Child Health.' Within this goal several agency priorities are noted and include: newborn metabolic and hearing screening and follow up, postpartum newborn home visit, reproductive health services, review of infant and unexplained child deaths, WIC caseload, and breastfeeding. Under Goal 2-E ‘Access to Comprehensive, Quality Care,' creating medical home partnerships (for all populations) are notable priorities.

The MCH Bureau and Title V are tasked with implementing programs and activities around these priority areas. With many competing demands, prioritization of programs and initiatives is critical. Decreasing state capacity resulting from ongoing fiscal challenges must shape the current focus of Title V. In addition to existing Title V outcome and performance measures, Title V resources continue to be devoted to carrying out activities related to agency priorities.

The priority for Title V dollars is advancing focus toward core public health functions of assessment, policy development, and assurance. As state personnel capacity continues to decrease, it is necessary to invest in workforce development to assure remaining public health workers have the knowledge, skills, and abilities to perform these core public health functions and essential services.

Notable Accomplishments

Pregnant Women, Mothers, and Infants-The March of Dimes recognized the agency with its National Award for Excellence in Newborn Screening for the comprehensiveness of the screening panel. A collaborative effort with the Deputy Commissioner for Health Services, the Bureau of Laboratories, and the agency's legislative liaisons, the Newborn Metabolic Screening Program successfully secured an increase laboratory fee for the initial specimen submitted for each infant from $42 to $68.51.

MCH staff and partners from the SC Department of Education and SC Campaign to Prevent Teen Pregnancy were one of 5 states awarded AMCHP Adolescent Preconception Health training collaborative. The team is receiving training, technical assistance, and a $2500 stipend to

implement their project.

Nurse-Family Partnership (NFP) has been newly implemented in SC. The evidence-based home visitation program aims to improve the health, well-being and self-sufficiency of low-income, first-time parents and their children. NFP is serving up to 100 mothers and babies in each of the 6 service hubs: Anderson, Berkeley, Charleston, Dorchester, Greenville, Horry, Lexington, Richland, and Spartanburg Counties.

Under the Birth Defects Prevention Act, the Birth Defects program designating the Greenwood Genetic Center to act on behalf of the program for Neural Tube Defect (NTD) prevention efforts. The Birth Defects Program shares surveillance data and supports GGC efforts to assure any women with a diagnosed NTD are referred to a prevention program that provides free folic acid and counseling.

Caring for Tomorrow's Children (CFTC) celebrated its 20th year of supporting mothers to be in 2009. This resource guide, a partnership effort between Title V, Blue Cross/Blue Shield of SC, and the Office of the Governor, emphasizes the importance of preconception health, prenatal care, signs and symptoms of preterm labor, postnatal care, well-child care, SIDS, and immunizations. It is available free of charge to every pregnant woman in SC.

The Division of Oral Health released state recommendations on Oral Health Care for Pregnant Women.

The Fetal and Infant (FIMR) program has collaborated with the Emergency Medical Services for Children program to carry out legislative mandates for shaken baby syndrome education. This partnership includes purchase of educational materials including a doll made to simulate the results of harsh shaking on a small child that is used in training sessions. The FIMR program also collaborated with the state level Safe Kids agency to expand the Cribs for Kids Program statewide. The program provides a crib for infants of low- income parents and provides them with education on safe sleep positions and proper crib environments.

Children-SC ECCS is working with Greenville County partners and the Connecticut Help Me Grow (HMG) Replication Team to establish the HMG combination of five interrelated components that work collaboratively. These components ensure child health providers are trained in effective developmental surveillance and screening, offer a free and confidential telephone access point that links children and families to existing services, maintain an inventory of community-based programs, and maximize use of resources available to those who contact the call center.

The Division of Oral Health created web based resources for women and medical/dental providers. "South Carolina Takes Action: Oral Health for the Young Child," is currently being used for the development of toolkits for clinicians and Early Head Start parent educators funded by the Academy of Pediatric Dentistry. In addition, a DOH representative was appointed to the Department of Education's Committee charged with revising the Health and Safety Standards. As a result, oral health was included within objectives across grade levels. SC is one of the few states to have oral health directly referenced within their Health and Safety Standards.

MCH staff provided technical assistance to plan and implement the 2010 SC Community Access to Child Health (CATCH) Meeting .The 27 practices represented at CATCH completed a survey from the Division of Oral Health (DOH), with seven practices indicating they currently apply fluoride varnish. Seventeen practices volunteered to focus test an Early Childhood Oral Health Toolkit for providers, other opportunities for further collaboration between SC AAP and DHEC were identified.

CSHCN-Transfer of Part C lead agency responsibilities to another state agency has allowed DHEC to increase focus on target population (especially those over age three), while continuing participation in the delivery of Part C services to infants and toddlers and on-going collaboration

with Part C lead agency in the State Department of Education.

Over the past year progress has been made in development of a new program data system. Regional and State staff participated in planning the development of the new system which should begin in the upcoming year. The new data system will improve program capacity for capturing, managing, and evaluating program activities related to CSHCN.

On-going services to 400-450 children annually at Camp Burnt Gin residential summer camp for CSHCN. Most of these children would not otherwise have access to a camp experience.

The DOH in collaboration with the CSHCN workgroup developed training for parents and childcare providers titled, "Oral Health for the Child with Special Health Care Needs." This training was delivered at the annual Family Connections Conference in March 2010, and at EdVenture's "Celebrating Children with Disabilities" conference. These events targeted parents, caregivers, teachers and providers of children with special needs.

Surveillance, Epidemiology, and Evaluation-The ongoing development and integration of health and health services data remains a priority for the Bureau. Over the past year the MCH Research and Planning Unit (RPU) has used vital records data, including linked birth/infant death files to provide key data and information to policy makers. Staff has also utilized PRAMS data to examine various aspects of maternal health. Studies examining the oral health of pregnant women have been used to support efforts of the Oral Health division and resulted in an oral presentation at the MCH Epi conference. Additional studies utilizing vital records linked to Medicaid billing data to examine gestational diabetes, prenatal care and postpartum diabetes screening have also been conducted and will be submitted for publication in the upcoming year.

B. Agency Capacity

State Budget Cuts-Since the beginning of SFY 2008 South Carolina has experienced significant budget reductions that have continued through the assessment period. Entering SFY 2010-2011 recurring State funds to the agency have been cut significantly. Efforts to secure one time funds to offset some of the reductions are often meet with mixed results. The ongoing fiscal challenges have resulted in a significant overall loss of workforce capacity. State and local public health departments have been forced to eliminate positions or leave vacancies unfilled at all levels. The impact of fiscal challenges permeates all programs and activities and erodes the critical public health infrastructure in the state. Voluntary retirement and early separation incentives have been instituted as a cost containment measure. This has accelerated the departure of many seasoned public health professionals and further decreased agency capacity to meet basic needs.

Despite the decreased capacity for providing direct services, MCH staff continues to increase their span of influence by working in conjunction with other state agencies and partners. MCH staff provides extensive input into design and implementation of service delivery systems through participating in community coalitions, advisory boards, joint cross-agency grant writing efforts, needs assessments, and public information efforts. Regional and Central Office program staff participate in the development and implementation of evidence-based interventions that target statewide and local issues related to improving the health and well being of MCH populations.

Comprehensive, Community Based, Coordinated, Family Centered Care

Promoting family centered care, community based coordination of services, and community based systems of care remains a priority. MCH supports medical home services in pediatric and family practices through on-going collaboration with the state AAP chapter. The division works closely with Family Connections by providing planning and implementation support of the Family Connection annually conference which works to get parents and providers critical information to improve care for special needs children. At the Regional level, staff works diligently at resource referral activities for both families and providers. Most children have access to primary care;

however, access to subspecialty pediatric care is not uniformly distributed and access can be challenging for families residing in rural areas. The Division of CSHCN is working with the network of Children's Hospitals to promote and develop community based networks of care, linking families with providers.

At the state level, there is considerable interaction with First Steps to School Readiness (First Steps). First Steps was named the lead agency for BabyNet services in January 2010. The Nurse Family Partnership (NFP) is also an initiative of First Steps. The Duke Endowment and the Blue Cross Foundation provided funding for the implementation. The extensive home visitation history of the public health agency has been invaluable to First Steps during this initial phase of development.

SC was one of ten states recently awarded a 5 year Centers for Medicare and Medicaid CHIPRA grant. The SC award is for $9.2 million dollars. The goals built into the grant come directly from MCH's long-term work on medical homes, and more recently the ECCS Implementation plan. This project has 4 key goals: demonstration the newly-developed quality indicators can be successfully utilized in pediatric practices; share key clinical data through a statewide electronic quality improvement network; develop a physician-led peer-to-peer quality improvement network; and expand the use of pediatric medical homes to address mental health challenges of children. MCH staff is on the Planning and Steering Committee for this grant.

Preventive and primary care services for pregnant women, mothers and infants:

MCH provides a variety of preventive and primary care direct services for pregnant women, mothers, and infants. Direct services are limited to four areas: family planning, pregnancy testing, postpartum newborn home visiting (PPNBHV), and Nurse Family Partnership (NPF). From 2003-2007 the family planning caseload decreased by 19%. A workgroup devised strategies to improve access to family planning services yielding activities that have seen caseload numbers increase. County health departments continue to provide pregnancy testing for women. Improving referral systems for both positive and negative tests has been a focus area for recent performance management activities.

PPNBHV have been a longstanding Title V program strategy. These early home visits serve as a gateway for assuring infants are connected to pediatric primary care, and mothers are connected to family planning services during the post partum period. Agency capacity to provide these visits has been severely impacted by staff shortages and Medicaid Managed Care reimbursement challenges. Considering these challenges, in SFY09 16,203 PPNBHVs were provided, representing 48% of the Medicaid eligible population.

Nurse-Family Partnership (NFP) has been newly implemented in SC. Four 4 local health departments currently house the program, serving approximately 400 first-time Medicaid eligible mother. Recent funding stemming from health care reform should result in a significant expansion so NFP into other counties.

MCH also has capacity to provide certain enabling services to this population. The program for Women, Infants, and Children (WIC) is within the MCH Bureau and is a critical resource for health food provision and education regarding healthy food choices/lifestyles. WIC food vouchers, nutritional education, and breastfeeding services to pregnant and postpartum women layer services at the foundation providing front line impact with the service population. About half of the state's pregnant women participate in WIC services.

The WIC Regional Directors plan to increase capacity in support of breastfeeding through use of The Business Case for Breastfeeding training. This training is part of a national initiative of the U.S. Health & Human Services, HRSA's Maternal and Child Health Bureau to increase breastfeeding duration and exclusivity rates among employed breastfeeding women.

Population based programs include newborn metabolic screening, birth defects surveillance, and newborn hearing and FIMR. The newborn metabolic screening program continues to provide screening and follow up for every infant born in the State. The program currently screens for 28 metabolic disorders recommended by the March of Dimes and the American College of Medical Genetics and an additional 24 secondary metabolic disorders also causing severe problems early in life. The program provides active follow up for ~100 infants last year. Lab fee increases for metabolic screening implemented during the past year will allow the program to sustain the current level of screening.

The South Carolina Birth Defects Program has lost a significant amount of capacity over the past year; however, the program has been able to continue surveillance for 42 of 45 defects recommended for surveillance by the National Birth Defects Prevention Network. The program continues to partner with the Greenwood Genetic Center to improve birth defects surveillance and prevention efforts in the State. Under the Birth Defects Prevention Act, the SCBDP entered into a MOA designating the GCC to act on behalf of the program for NTD prevention efforts.

The Newborn Hearing Screening Program has improved and expanded capacity for surveillance and follow up activities. During the past year the program has been successful in streamlining the programs data system infrastructure to create a comprehensive record for each child screened and requiring follow up. This will provide more accurate program surveillance and follow up data.

MCH continues to support local FIMR efforts; however, local capacity to support the process has been greatly reduced with only 9 of 46 counties maintaining active local FIMR groups.

The DOH produced recommendations/guidelines for oral health care and pregnant women. Postcards announcing the web-based resources for the recommendations and referral forms were sent to 260 obstetricians, family practitioners and midwives across the state.

MCH also invests in infrastructure building activities directed at this population. MCH is working to improve capacity for providing epidemiological and program information to stakeholders. Efforts to integrate surveillance program data within existing web-based platforms have been successful. Birth defects surveillance and newborn hearing data are both housed within the Birth Exchange Engine (BEE). During the past year, components of the newborn hearing program data system previously supported by separate applications were migrated to the BEE. This should improve the accuracy of surveillance and follow up activities for this program.

Preventive and primary care services for Children:

Capacity to provide preventive and primary care services for children has shifted away from direct services. Direct services to children would be limited to adolescents receiving services through DHEC family planning, STD/HIV clinics.

MCH does continue to provide enabling services. The School Dental Prevention Program provides preventive dental services to underserved populations. In the 2008-2009 school years, the five programs provided dental sealants for 7,194 children. WIC continues to a significant factor enabling the nutritional development of children in the State. As the economy continues to struggle, need for WIC services among children continue to increase.

Population based efforts related to medical home partnerships continues to be a priority area for MCH.

Infrastructure building activities around services for children is ongoing. The DOH in collaboration with the Coalition's Early Childhood Workgroup produced oral health recommendations for young children. In March 2010, the DOH received funding from the Academy of Pediatric Dentistry to develop Clinician and Early Head Start Parent Education toolkits as part of SC's Head Start Dental Home Initiative based on the recommendations.

Services for CSHCN:

The MCH target population for CSHCN services is children with chronic illnesses or physical disabilities. MCH does not serve children with emotional or behavioral conditions not associated with a chronic illness or physical disability. DHEC staff provides limited direct care in selected locations for specialty clinics. DHEC remains under contract with First Steps to provide a set array of services; however, we are no longer responsible for the oversight and implementation of services to those from birth to 3 with developmental disabilities.

Some enabling services (purchase of care, financial assistance) are provided to children in target population based on income criteria. DHSS contracts with DHEC for the "gatekeeper" role for enrollment of and provision of hemophilia products, orthodontia care and audiological services. Care coordination (assistance with identifying and obtaining needed health care services, beyond mere information and referral) is provided as needed to children who receive financial assistance, and to other children in the target population as resources permit.

Among population based services, MCH provides information and referral services on request of any family member or provider. Nine regional offices for CSHCN services are located in the eight DHEC administrative regions. These offices are usually the first point of contact for families and professionals. Each office is staffed by at least one RN, administrative staff. The offices have varying access to nurses and social worker familiar with local and statewide resources as well as needs of CSHCN and their families. Medical consultation is available at all times to state and local DHEC staff working with CSHCN through contract with the University of South Carolina, Department of Pediatrics.

State level program managers now include two RNs and one social worker with access to nutrition consultation on an as need basis. State level staff process approximately 1000 invoices for covered services each month. Total reimbursement from CRS for these services is in excess of $2 million annually.

Capacity for rehabilitative services for the blind and disabled under 16 receiving SSI benefits is limited. The program receives SSI referrals alerting them to send a letter of notification about additional services and resources. Beyond these activities, the extent of services is limited to those offered by existing CRS programs, such as transition to adult care planning.

Culturally Competent Care:

All new employees are required to take the Culturally and Linguistically Appropriate Services (CLAS) course within the first year of employment. Additionally, all employees are required to receive refresher training on CLAS annually through the agency's E-Learning System. A copy of the agency policy is available as an attachment for review.

Policies and procedures are also in place to ensure that agency informational/educational materials convey appropriate public health, be culturally sensitive to the intended audience, are available in multiple languages, and are created at an appropriate reading level.

DHEC staff and clients have access to interpreter services through systems established and maintained by the DHEC Office of Minority Health. Bilingual staff are hired for available positions as circumstances allow. Cultural competency training is a required element of DHEC staff orientation. The parent support contractor (Family Connection of SC) also employs bilingual staff and actively recruits bilingual parents for participation in all activities. Information and training sessions related to cultural competence are included in annual Family Connection conference which is co-sponsored by DHEC.

MCH staff is active members of the Perinatal Awareness for Successful Outcomes (PASOS)

Advisory Council. The PASOS program empowers Latina women in SC to gain access to resources and have healthy families one Paso (step) at a time and provides information in a way that can be understood, supported, and adopted by the community.

Statutes:

Although there are no statues directly mentioning Title V authority, several South Carolina statues have direct implications for DHEC and the MCH Bureau. Section 44-37-30- Establishes the newborn metabolic screening program with DHEC and requires every child born in the state, with the exception of religious exceptions, to have neonatal testing to detect inborn metabolic errors and homoglobinopathies. Section 44-37-40- The Universal Newborn Hearing Screening and Intervention Act requires all hospitals with more than 100 deliveries annually to screen for hearing loss and those with less than 100 deliveries annual are required to inform parents of newborn hearing screening. Those with hearing loss are to be referred for follow up interventions. DHEC maintains oversight and coordination of program activities. Section 44-38-50- Requires hospitals to make available a shaken baby video informing parents of the dangers of shaking an infant or young child before hospital discharge. DHEC is responsible for approving and making videos available child care providers/facilities. Section 44-44-10- The South Carolina Birth Defects Act establishes a comprehensive birth defects program housed at DHEC that is responsible for surveillance, prevention, referral, and reporting of birth defects in the state. Section 61-16- Requires the state hospitals to organize into a regionalized system of care of newborn care. Section 44-1-280- Requires DHEC in establishing priorities and funding for programs and services which impact on children and families during the first years of a child's life, within the powers and duties granted to it, must support, as appropriate, the South Carolina First Steps to School Readiness initiative, as established in Title 59, Chapter 152, at the state and local levels.

An attachment is included in this section.

C. Organizational Structure

The South Carolina General Assembly created the Department of Health and Environmental Control (DHEC) in 1973. The agency is under the supervision of the Board of Health and Environmental Control, which has seven members, one from each of the six congressional districts and one at large. The governor with consent and approval from the senate appoints members. The Agency is headed by the Commissioner, Mr. Earl Hunter and contains five Deputy Areas: Health Services, Health Regulations, Environmental Quality Control, and Ocean and Coastal Resource Management and Administration.

DHEC is a centralized public health organization with central, regional, and local public health offices carrying out various aspects of public health practice. At the state office, Health Services has four Bureaus: Maternal and Child Health, Disease Control, Community Health and Chronic Disease, and Laboratory. In addition Health Services has five Professional Offices: Primary Care, Nursing, Social Work, Health Education, and Nutrition.

Oversight of the Title V program is housed within Maternal and Child Health Bureau. The MCH Bureau works centrally to plan, implement, and monitor Title V programs and activities. There are four divisions within the MCH Bureau that carry out aspects of Title V programming. The Division of CSHCN, Women's and Children's Services (WCS), Women Infants and Children (WIC), Oral Health, (DOH) and the Research and Planning Unit (RPU).

The Division of CSHCN contains the Children's Rehabilitative Service Program (CRS), components of BabyNet, Orthodontia, Hemophilia, and Sickle Cell services and Camp Burnt Gin. The Division of WCS contains program areas including Newborn Metabolic Screening, Newborn Hearing Screening, Family Planning, Child/Adolescent Health, Care Line, Sexual Assault Prevention, PPNBHV, and the Early Childhood Comprehensive Systems (ECCS) initiative. ECCS

facilitates a leadership group concerned with cross-agency services coordination for children 0-5, including children with special needs. The Division of WIC implements the federal WIC program funded through the Department of Agriculture. The Division of Oral Health contains the School Based Sealant, Water Fluoridations programs, and facilitates the South Carolina Oral Health Advisory Council with workgroups focusing on children, and CSHCN. The Research and Planning Unit houses all Bureau epidemiology activities and contains Birth Defects Surveillance, FIMR, and Perinatal Regionalization.

In addition to the MCH Bureau, Title V funding also supports programs/initiatives within 8 Regions encompassing 46 local health departments. Regional offices and their local health departments offer a range of services. These offices include direct clinical services such as family planning and WIC as well as community based health promotion activities. Each region seats a Health Director, a Child Health Program Manager, Nurse Manager, and other appointments responsible for the planning, implementation, and evaluation of ongoing Title V programs/initiatives. Central office staff works in coordination and collaboration with the regional leadership to develop plans and assure services are provided that are meaningful to each region considering their unique needs.

D. Other MCH Capacity

Staff working on Title V related programs/initiatives span the agency and include both state and local persons. Within the MCH Bureau staffing capacity has decreased drastically over the past year. Retirements, buy outs, and hiring freezes have reduce the size of the workforce through attrition. Existing staff have added additional duties and have worked to sustain existing efforts.

MCH Bureau

Brenda Martin, RNC, MN, CNAA, serves as the MCH Bureau Director and Director of Title V Programming. She is responsible for providing leadership and oversight of MCH programs and activities. Ms. Martin has a long history of public health experience in various roles within DHEC and has also worked in the managed care environment. She brings knowledge, experience, and skills needed to facilitate the complexities of collaboration with managed care organizations. She is also a member of the South Carolina Board of Nursing

Nathan Hale, PhD, serves as the MCHB Deputy Director. He recently earned his doctorate degree in Health Services Policy and Management from the University of South Carolina, Arnold School of Public Health. Mr. Hale serves as the Bureau's lead epidemiologist and manages the Research and Planning Unit. He has held positions in two states as an epidemiologist and a district health director. He is an experienced researcher and has multiple peer reviewed publications.

CSHCN

Cheryl Waller, BSN, MPH, serves as the Director of the Division of CSHCN. Ms. Waller joined DHEC in April 2005 from North Carolina. She also has over 25 years of nursing and management experience at the state and federal levels.

Leanne S. Bailey, BSN, serves as the Assistant Director of the Division of CSHCN. She brings over 20 years experience with CSHCN at the regional level in service delivery and program management.

Carole Scott, RN joined the DHEC Division of CSHCN as a program coordinator in December 2009. She has 14 years of experience working with CSHCN populations and has held several positions at the local and regional level before joining Central Office.

Martha Hinson MSW, LMSW, serves as the BabyNet coordinator. She has 20 years of experience and has been with DHEC since 1994 working at the Regional level, before joining the Division of CSHCN this past year.

WCS

Lucy Gibson MSW, LMSW has served as the director of WCS since July 1, 2008 and the State Adolescent Health coordinator since January 2005. Prior to that she served as the WCS and CSHCN social work consultant and a District Director of Public Health Social Work. Ms. Gibson has been employed by DHEC since 1989. She is a graduate of the UNC Management Academy for Public Health and is credentialed as a Certified Grants Specialist.

Beth De Santis, APRN, MSN, WHNP joined MCH as the Family Planning Director. She brings a wealth of knowledge and experience to this position. She has worked at the regional level for 9 years. Her positions at DHEC have included Family Planning/STD/HIV/Immunization Program Nurse Manager and Clinical Services Director.

Kathy Tomashitis, MNS, RD, LD has been the manager of the Newborn Metabolic Screening program since 1994. She also supervises the activities of the Newborn Hearing Screening Program. In addition, Ms Tomashitis provides consultation to the Division of CSHCN regarding special and metabolic formula requests for eligible children.

Tara Carroll, MCD, CCC/A is an audiologist and has served as program manager for DHEC's newborn hearing screening program and audiology consultant to Children's Rehabilitative Services and BabyNet (Part C) since February 2005. Prior to that she practiced audiology for 10 years in non-profit United Way community agencies and an ENT physician's office.

Rosemary L. Wilson, MSW, LMSW has served as coordinator for the Early Childhood Comprehensive Systems Initiative since 2006. Prior to this she worked 15 years in a district office and duties included management of care coordination for CSHCN, systems coordination for BabyNet Part C, community outreach coordinator. She has 30 years of social work experience with children and families in school, hospital, and mental health settings.

Jane Key, MPA is currently the Sexual Violence Services Program Coordinator and has held this position since September of 2003. She is also serves as the State Women's Health Director having had this additional position since February of 2009. She is a graduate of the University of South Carolina (USC) Public Administration program and recently completed all requirements for the Arnold School of Public Health at USC Public Health Certificate Program.

Sarah Fellows, APRN, P/FNP-BC has been a nurse consultant for WCS since 1996. Prior to that she was a public health nurse for 12 years, in the Catawba Health District, working in all health services programs. Mrs. Fellows received her Master of Community Health Nursing from the University of South Carolina in 1995, her Pediatric Nurse Practitioner certification in 1995, and her Family Nurse Practitioner Certification in 1999.

WIC

Burnese Walker, MS, RD serves as the WIC Director. She has over 20 years experience working with WIC programs in two states (Georgia and South Carolina). She has also worked with School Food Services at the SC Department of Education.

Oral Health

Christine Veschusio, M.A., serves as the Oral Health Division Director. She has been with the DOH since October 2002. Before becoming the Division Director, she served as the School Program Coordinator and the Project Director for the Robert Wood Johnson Foundation More

Smiling Faces in Beautiful Places program. She also practiced clinical dental hygiene and was an Associate Professor for Horry-Georgetown Technical College before joining DHEC.

Carol Reed, MPH, has over 5 years experience with MCH in Systems of Care and the Medicaid MEGA Administrative Services Contract. She joined the Division of Oral Health in August 2009 as the Program Coordinator for the Centers for Disease Control Oral Health Cooperative Agreement. She also continues to work with the MEGA Contract in the areas of medical/dental homes, Family Planning Waiver, and Medicaid utilization/eligibility.

Wes Gravelle, MPH currently serves as an epidemiologist and surveillance coordinator for the Division. He also provides limited support for MCH Bureau epidemiology activities. Mr. Gravelle has worked for several state agencies in various roles focused on data and surveillance.

Research and Planning Unit
Breana Lipscomb, MPH serves as the state FIMR coordinator and has been with MCH for 2 years. In addition to FIMR duties, Ms. Lipscomb is also involved in numerous perinatal projects MCH planning activities including the 2010 needs assessment.

Kirk Shull, B.S., serves as the Research and Planning Administrator for the Birth Defects program. Mr. Shull has over 20 years experience working with data, information systems, and GIS functions within the agency. In addition to maintaining the BEE, Mr. Shull's duties include the development of additional program data within MCH

Parents of Special Needs Children

First Sound, the state's Early Hearing Detection and Intervention (EHDI) Program, does employ a parent that serves as a DHEC volunteer. Her key focus is to establish an SC chapter of Hands & Voices, a parent-driven, non-profit organization providing families with the resources, networks, and information they need to improve communication access and educational outcomes for their children who are Deaf and Hard-of-Hearing.

There is no position in the CSHCN division filled by a parent to provide leadership and technical assistance around issues uniquely parenting related. An agency-wide survey is underdevelopment to determine the number of DHEC employed parents who also have children with special health care needs. They would be asked to volunteer as a parent liaison/advisor on a variety of program planning, evaluation outreach activities. Family Connection, SC parents most often provide this needed support to the Bureau.

E. State Agency Coordination

While DHEC is not a member of the Governors cabinet, it is a quasi cabinet Agency with a board appointed by the Governor. However, the agency maintains close working relationships with staff at fellow human services agencies. MCH collaborates with all related state agencies and multiple private organizations to prioritize needs, avoid duplication of service and effort, and blend resources to meet needs. As our capacity continues to decrease, this coordination within and among State Agencies is a critical priority. Several examples illustrate the type of State Agency Coordination MCH continues sustain.

External Coordination:

Department of Health and Human Services (Medicaid)-Coordinating with DHHS/Medicaid is critical for MCH operations. The MCH Bureau works with DHHS at multiple levels related to numerous aspects of health services for mothers and children. DHHS is represented on multiple MCH sponsored councils/committees that include: Commissioners OB Task Force and Pediatric Advisory Council meetings, ECCS Executive Committee, Oral Health Advisory Council and

Coalition, the South Carolina Birth Defects Advisory Council, Commissioner's Pediatric Advisory Committee, and Commissioner's Obstetric Task Force. Individual programs within the Bureau coordinate activities with DHHS on an ongoing basis. The Division of CSHCN meets regularly with DHHS and MCO representatives to coordinate services and payment of services for children with special needs. Representatives from WCS and Family Planning coordinate activities related to the Family Planning waiver and access to contraceptive services for eligible women. The Bureau maintains a large administrative contract with DHHS for the purposes of enrollment outreach and selected services for children and pregnant women. Perinatal Reginalization staff coordinates with DHHS on aspects of perinatal services related to maternal/fetal transport as well as infant back transport from the Regional Perinatal Centers. MCH staff also participates in the Medicaid Medical Advisory Council and Medicaid Managed Care Council

South Carolina is slated to receive 2.3 million dollars from health care reform for the purposes of providing evidence based home visitation programs (EBHV). South Carolina Children's Trust has been designated as the lead agency for the grant application and oversight of the implementation. MCH will be working very closely with Children's Trust and other state agencies including the Department of Education and South Carolina First Steps, to coordinate needs assessment and implementation efforts in South Carolina.

WCS-Representatives from WCS are also represented on the Evidence Based Home Visitation Funders Committee, NFP Advisory Board, First Steps Advisory board, and the Early Childhood Advisory Council.

The ECCS Executive Committee includes representatives of SC Departments of Social Services (DSS), Health and Human Services (DHHS) (Medicaid Agency), Mental Health (DMH), Education (DOE), Disabilities and Special Needs (DDSN), Alcohol and Other Drug Abuse Services (DAODAS), Head Start, First Steps (SCFS), Children's Trust of South Carolina (CTSC), Office of Research and Statistics (ORS), and Family Connection. With 2010 funds for implementation, ECCS has contracted with Dr. Francis Rushton, a Beaufort Pediatrician, and AAP Region 4 board member to continue his leadership in working with individual pediatric practices to examine quality measures to enhance their role as a medical home. Another contract is with the SC AAP to lead an annual CATCH meeting bringing practices across the state together for a learning collaborative around quality improvement. With the USC School of Medicine, Dept. of Neuro Psychiatry there is a contract to provide state leadership in advancing training and service provision around early childhood mental health and social emotional issues, and with the USC College of Education, a contract will support cross-agency training using the Center for Social Emotional Foundations of Early Learning modules.

MCH has a long history of collaboration with the Department of Education. The Division of WCS employs a School Nurse Consultant who works across agencies to promote the health of children in schools. The School Nurse Consultant is responsible for coordinating school health activities in the state. An example of the partnership between these agencies and the local Boards of Education was their joint plan to address last years H1N1 pandemic to provide school based immunizations. Participation in immunizations at school-based clinics was well received and many children were immunized for H1N1 through the schools. Until recently, WCS has also employed a School Social Work Consultant who coordinated school social work activities on a statewide basis. The ability to refill this position is uncertain at this point in time.

The Sexual Violence Services Program has contractual and coordinating relationships with all the domestic violence and sexual assault centers as well as the State Coalition Against Domestic Violence and Sexual Assault (SCADVASA).

Adolescent Health and Family Planning work closely with the SC Campaign to Prevent Teen Pregnancy.

The WCS Division Director is a member of the Community Engaged Scholars Program Advisory

Board, a partnership between a large FQHC, Eau Claire Cooperative Health Centers, Inc. and the Medical University of South Carolina. This partnership was formed to evaluate the Vitamin D status of pregnant women and their newborns with a particular focus on women of color due to studies reporting severe Vitamin D deficiencies in these populations.

MCH provides technical assistance to regions for program development, implementation, and evaluation. Staff often provides community-based training programs on specific topics such as postpartum depression, sexual violence prevention, abuse and neglect, and a variety of health issues.

CSHCN-DHEC staff (state and local) routinely collaborates with counterparts in state departments of mental health, social services, education, human services (Medicaid), vocational rehabilitation regarding planning and implementation of service for CSHCN. There exists an on-going contractual relationship with Family Connection (Family Voices) for parent support services. The DHEC Commissioner's Pediatric Advisory Committee meets quarterly to advise the Commissioner and the MCH Director on issues that include CSHCN. Staff maintains regular working meetings with early intervention service providers related to services for CSHCN under age five. Both state and local staff regularly communicates with counterparts in mental health, social services, education, and human services (Medicaid) regarding eligibility, service, and payment needs.

Oral Health-The Oral Health Division continues to facilitate the SC Oral Health Advisory Council and Coalition. The Advisory Council includes representation from Medicaid/SCHIP, FQHCs, Department of Education, the dental school, Head Start, Healthy Start, First Steps, community members and other agencies and organizations. This group reviews and makes recommendations on policy and practice issues that emerge from DHEC and the coalition workgroups. The workgroups contain broad stakeholder membership and are responsible for moving the SOHP forward. In addition, a DOH representative also participates in the Early Childhood Comprehensive Systems group.

Other Program Coordination-Title V continues to limit direct services that include EPSDT. Local health departments no longer routinely provide EPSDT services. Instead, the role has shifted to provision of assurance that services are being provided. MCH monitors EPSDT services and works to improve the provision of services within a medical home. Title V also works closely with other providers of direct services. The Title X Family Planning Program and WIC both reside within the MCH Bureau. Organizational alignment of these programs within the MCH Bureau promotes coordination of services. Family Planning and WIC represent the few remaining MCH programs that provide direct or enabling services to women and children. Title V works to coordination services with populations utilizing these direct services.

Internal Coordination:

In addition to the provision of services with the Bureau, MCH also coordinates activities with other DHEC Bureau's/Programs on related services. Notable efforts include efforts related to tobacco cessation, motor vehicle crashes, obesity prevention, and immunizations.

The Division of Tobacco Control (Bureau of Community Health and Chronic Disease Prevention) has several initiatives pertinent to pregnant women, mothers and infants. In addition to efforts targeting smoke free ordinances, the division also received stimulus funds to target tobacco reduction efforts among pregnant women. The program targeted counties with a high density of pregnant smokers and ran awareness add in target areas. The Quit Line has seen an increase in the number of pregnant women calling for services.

Motor vehicle crashes are the leading cause of death among children over the age of one. The Child Passenger Safety Program within the Bureau of Community Health and Chronic Disease continues working to prevent and reduce deaths and injuries due to motor vehicle crashes

through outreach education, counseling and demonstration of proper car seat instillation, and training.

Through the ECCS partnership with DSS and the states Child Care Block Grant leadership, the Division of Childhood Obesity is working on policy changes in state requirements for child care centers related to nutrition and physical activity. Recent activities include aligning nutrition and physical activity standards across multi programs, and offering bonus reimbursement to centers that participate in assessment of their practices coupled with an improvement plan.

The Immunization Division (Bureau of Communicable Disease) is currently working with the SC Hospital Association and Medicaid to cocoon newborns and infants, too young to receive an initial DTaP vaccination, against pertussis. A task force has been formed to address Tdap protocol for postpartum areas, educating the mother concerning her infant's risk for pertussis and offering Tdap vaccination to these mothers prior to hospital discharge.

MCH also works very closely with the Office of Public Health Surveillance and Information Systems within the Commissioners Office on projects related to data and information systems. MCH has worked with PHSIS to develop web based surveillance systems for certain programs, create web based data modules allowing access to MCH related data including vital records, PRAMS, and BRFSS, and provided GIS support for ongoing mapping projects.

F. Health Systems Capacity Indicators

Introduction

The outlined Health Systems Capacity Indicators serve as important measures for obtaining a broad sense of the existing capacity of the health system for mothers and children. Annual reporting of these indicators allows MCH to fill our assurance role by monitoring specific capacity measures and providing feedback to partners related to trends and areas of need.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	40.6	38.9	36.9	30.9	29.2
Numerator	1137	1109	1047	949	916
Denominator	280272	285202	283488	307354	313594
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
Since 2005 there has been a 28% decline in the rate of children less than 5 hospitalized for asthma. MCH sustains no programs specifically targeting asthma; however, ongoing initiatives working to improve access to quality primary care delivered in a medical home contributes to asthma management. Improvements in this area certainly contribute to the ongoing decline related to this indicator.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	77.6	80.4	83.5	85.3	84.6
Numerator	28354	30751	34235	34959	34827
Denominator	36532	38228	40981	40989	41190
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
The percent of Medicaid enrollees <1 receiving an EPSDT has remained stable over the past year. Few EPSDT's are provided through health department clinics and are primarily delivered through the private sector. MCH continues to plan assurance role by monitoring system performance related to this indicator and continuing work to assure access to preventive health services for children.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	1	1	1	1	1
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Children <1 not eligible for SCHIP

Notes - 2007
Children <1 not eligible for SCHIP

Narrative:
Children under one are not eligible for SCHIP in South Carolina.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	85.3	84.6	86.0	86.8	86.8
Numerator	49087	52629	53969	54626	54626
Denominator	57538	62187	62753	62898	62898
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Narrative:
The percent of women with adequate or better prenatal care has remained constant. Ongoing expansion of Medicaid Managed Care has created some challenges for Medicaid eligible women in accessing early and adequate care. Variation in auto enrollment practices coupled with variation in provider contracts has provided significant challenges for some women seeking these services. Moreover, at least one hospitals located in a rural area no longer provides delivery services, which has further created barriers in access to care. MCH continues to work through our Perinatal Regional Hospitals and Systems Developers to address these issues. MCH also convenes the Commissioners OB Task force which provides a venue for policy discussions. Representatives from Medicaid attend this meeting.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	89.1	89.1	85.6	86.4	95.1
Numerator	438363	438526	421130	417235	453089

Denominator	492192	492000	492000	483127	476591
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: U.S. Census Bureau, 2008 American Community Survey, 2008 1-Year PUMS Data.

Data is provisional and is not from a state projection.

Note: Under 185% FPL was used from the Census data since Medicaid allows for income disregards which would drop the FPL to 150% and below.

Narrative:
The percentage of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program has increased over the past two years. In 2007, the percentage dropped to 85.7% from 89.1%. In 2008, the percentage increased to 86.4% and in 2009 the percentage increased to 95.1%, the highest percentage in the past five years. This increase could be due in part to the 2008 SCHIP expansion that extended coverage to up to 200% of the poverty level.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	60.1	61.7	62.3	65.0	67.4
Numerator	60937	62879	62878	65236	71200
Denominator	101331	101877	100885	100319	105591
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:
South Carolina Medicaid children have experienced an increase in access to preventive dental care for children aged 6 to 9 years. Several factors have contributed to the observed increase and includes 1) the School Dental Prevention Program administered by DHEC in partnership with public and private providers; 2) Dental Medicaid provider reimbursement rate increase from 35% to 75% of the dentists average fees.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	18.0	46.6	23.1	22.1	23.1
Numerator	1253	7380	4337	4000	4000
Denominator	6959	15828	18760	18109	17353
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
denominator:

SOURCE: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data.
Table produced by SSA/ORDP/ORES/DSSA. Contact Clark Pickett, (410) 965-9016 or clark.pickett@ssa.gov for further information.

numerator: estimates

Notes - 2007
Denominator comes from SSA Supplemental Security Record for children under 18 with SSI in SC. CDC Wonder website was used to estimate the population in SC under 18 and under 16. The percentage of under 18/ under 16 was applied to the "SSI under 18" to get the final denominator. Numerator is from semi-annual report #T0701FT to get total number of Medicaid under 16. Data was used from Region 3 databases which kept good records of this information and found that 34.4% of their Medicaid recipients under 16 had SSI. We applied that 34.4% to the entire CSHCN population under 16 with Medicaid (4,337) to get the final numerator.

Narrative:
The proportion of SSI beneficiaries less than 16 receiving rehabilitative services has remaned stable over the past two of years. All referrals received by SCDHEC for SSI recipients less than age 16 years old are sent information on resources and programs for CSHCN in South Carolina. Families are provided an overview of services and the contact information for the state CSHCN program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	payment source from birth certificate	11.8	8.6	10.2

Narrative:

The percent of low birth weight outcomes among Medicaid enrollees is higher that what is observed among the non-Medicaid population. Medicaid pays for over half of all births in the State; therefore, disparities in outcomes among Medicaid enrollees can have a significant impact on the State. Despite the disparity in low birth weight outcomes, Medicaid enrollees continue to have equitable access to high quality sub-specialty care through the strong perinatal regionalization system in South Carolina. Birth weight specific mortality rates are comparable between the population groups. MCH continues to maintain ongoing dialogue with DHHS regarding policy related to women/infant health services necessary for improving outcomes.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	10	7.2	8.5

Narrative:
Data for this particular indicator is not available at this time. However, infant mortality rates follow similar patters to what is observed related to birth weight. MCH continues to focus on reducing infant mortality through numerous outlets, most of which target low income, vulnerable populations.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	60.1	76.7	68.6

Narrative:
The proportion of Medicaid eligible women receiving prenatal care during the first trimester is markedly lower than what is observed among the non-Medicaid population. Expansion of Medicaid Managed Care and auto enrollment policies could have a significant impact on this particular indicator. MCH has worked with OB providers and Medicaid to illuminate these challenges and work towards solutions to streamline the process. Additional quality improvement initiatives within 2 DHEC public health regions are focused on improving entry into prenatal care among health department clients, most of which are Medicaid eligible.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	87.2	84.9	86

Narrative:
The percent of pregnant women with adequate or better prenatal care by payment source is somewhat comparable. A slightly higher proportion of Medicaid eligible women received adequate or better prenatal care; however, this could be reflective of higher risk pregnancies resulting in intensive prenatal care utilization.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	185

Narrative:
No change for infants 0-1 percent of poverty level of eligibility.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

women.		
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	200

Narrative:
The SCHIP stand alone program covers children from over 185% of poverty up to 200% of poverty. The number of enrollees increased from 13,559 in May, 2009 to 15,529 in May, 2010. The increased number of enrollees was lower than anticipated.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	185

Narrative:
No change in the percent of poverty level for FP Waiver or Medicaid eligible pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS	3	Yes

Hospital discharge survey for at least 90% of in-State discharges		
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
MCH is fortunate to have access to a tremendous amount of data. MCH has direct access to linked birth/infant death files, PRAMS, WIC and BRFSS. In addition, the State maintains a data warehouse that makes available data from Medicaid claims, hospital discharge records, and other social services program data. MCH maintains the South Carolina Birth Defects Surveillance program, which monitors birth defects through age 2. During the past year these files have been used extensively for epidemiologic and program planning purposes.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2011

Narrative:
MCH receives reports highlighting YRBS findings. We do not have direct access to this data. The survey is implemented through the Department of Education.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Beginning in FY 2008 South Carolina has experienced significant budget reductions that have continued through the assessment period. This has resulting in a significant overall loss of capacity. State and local public health departments have been forced to eliminate positions or leave vacancies unfilled at all levels. The impact of fiscal challenges permeates all programs and activities and erodes the critical public health infrastructure in the state.

These realities provide a backdrop for the focus of the needs assessment, and establishment of future priorities. Priority needs and performance measures identified during the 2010 assessment process are largely reflective of the current capacity within the agency and MCH. Focus was placed on identifying needs and measures within the scope of existing program capacity and developing performance measures that are measurable and practical. New priorities and performance measures reflect a fundamental need to re-build an eroded infrastructure, strengthen working relationships within and outside the MCH Bureau, and strategically position MCH to provide core public health functions within the evolving health care environment following the passage of health care reform.

B. State Priorities

Completion of the 2010 needs assessment provided the opportunity to re-focus State priorities and establish new directions for the next 5 year planning cycle. To complete the assessment MCH staff complied data and information using both quantitative and qualitative methods, conducted quasi-focus groups with providers to obtain perspective on health and health service needs, held key stakeholder meetings around each of the established MCHB population groups to review and discuss relevant data and information, conducted site visits to each of 8 DHEC public health regions to gain local perspective on needs and capacity, and utilized various components of CAST-V methodology to assess current capacity to perform core public health functions and essential services. MCH leadership compiled all available information stemming from the assessment process to establish priority areas of need and associated performance measures for the next five year planning cycle.

Priority needs and performance measures identified during the 2010 assessment process are largely reflective of the current capacity within the agency and MCH. Focus was placed on identifying needs and measures within the scope of existing program capacity and developing performance measures that are measurable and practical. New priorities and performance measures reflect a fundamental need to re-build an eroded infrastructure, strengthen working relationships within and outside the MCH Bureau, and strategically position MCH to provide core public health functions within the evolving health care environment following the passage of health care reform.

The new priorities include:
1. Improve overall pre/inter-conception health status of South Carolina women (Infrastructure Building Service)
2. Reduce the annual rate of maternal deaths (Infrastructure Building Service)
3. Reduce the number of infant deaths due to SIDS/Unsafe sleep environments (Enabling/Population Based Servide)
4. Increase the knowledge of appropriate child social-emotional development among parents and early childhood service providers (Enabling Service)
5. Improve systems for obtaining parental involvement in the planning, implementation, and evaluation of DHEC programs and services for CSHCN (Infrastrucuture Buillding Service)
6. Promote and support regional based planning of MCH programs/initiatives (Infrastructure Building Service)

7. Increase the degree to which MCH is actively engaged in ongoing assessment and assurance activities (Infrastrucure Building Service)
8. Improve coordination of activities related to existing performance MCHB National Performance Measures with a focus on those outside of the MCH Bureau (Infrastructure Building)
9. Invest in building existing MCH workforce leadership competencies and skills related to data analysis and program evaluation (Infrastructure Building Service)

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	115	105	112	111	1
Denominator	115	105	112	111	1
Data Source				MCH	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
All metabolic screening is data CY. New data is CY 2000, so 2009 is not yet available.

Notes - 2007
2006 data has been finalized

a. Last Year's Accomplishments
The newborn metabolic screening program continues to provide a high level of short term follow-up services to infants born in South Carolina who screen positive for one of the conditions on the test panel. The newborn metabolic screening program manual, medical provider information sheets and parent information sheets are now posted on the agency's internet site as another means of ensuring that all involved in the screening process have the most up-to-date information possible. Additionally, the program manager provided an update on newborn screening activities at the state Genetics Conclave in October 2009. Collaborative meetings continue to be held every six months with staff from Greenwood Genetic Center and, beginning in November 2009, with staff from the Medical University of South Carolina genetics program. These meetings provide an opportunity for coordination of services and case review of infants that have abnormal metabolic screening results. The March of Dimes awarded its National Excellence in Newborn Screening to the agency for the comprehensiveness of the screening panel and long standing commitment to maintaining quality services. After an extensive data review, the laboratory changed the cutoff for screening for cystic fibrosis in an effort to ensure that false negative test results are minimized even further. Other upgrades include the installation of new tandem mass

spectrometers for metabolic screening and new reagent kits for congenital adrenal hyperplasia screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contact medical provider to initiate follow-up process for infants with screening results outside of normal limits.			X	
2. Track infants with screening results outside of normal limits to case resolution.			X	
3. Inform parents of infants whose specimen was deemed unacceptable for routine reporting of test results.			X	
4. Perform routine assessment of system of care for infants and children with conditions identified through metabolic screening to ensure that all affected persons are identified promptly and appropriate treatment initiated.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current activities include immediate physician notification by phone and fax when an infant with a screening result highly indicative of morbidity and/or mortality is found through testing. Infants whose screening results are outside of normal limits, but more likely to be considered false positive are also tracked to ensure repeat specimens are received in a timely manner. Parents of infants whose specimen could not be used by the laboratory receive a letter from the program encouraging prompt repeat screening.

c. Plan for the Coming Year

The newborn metabolic screening law and regulation will be updated to reflect current terminology and to revise the provisions related to storage and use of residual blood spots. The program will continue to evaluate the appropriateness of screening panel expansion as recommended by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. We also plan to reconsider the issue of data integration among newborn metabolic screening, newborn hearing screening, birth defect surveillance and birth records.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**62100**			
Reporting Year:	**2008**			
Type of Screening Tests:	**(A) Receiving at least one**	**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that**

	Screen (1)				Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	8	0.0	8	2	1	50.0
Congenital Hypothyroidism (Classical)	1302	2.1	1302	22	22	100.0
Galactosemia (Classical)	354	0.6	354	0	0	
Sickle Cell Disease	59	0.1	59	51	51	100.0
Biotinidase Deficiency	12	0.0	12	3	3	100.0
Cystic Fibrosis	118	0.2	118	12	12	100.0
Sickle Cell Trait	1887	3.0	1887	0	0	
Other Amino Acid Disorders	226	0.4	226	6	6	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	290	0.5	290	4	4	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	7	0.0	7	5	5	100.0
Other Organic and Fatty Acid Disorders	239	0.4	239	6	6	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	75	75	80	80
Annual Indicator	74.1	74.1	59.4	59.4	59.4
Numerator	630	630	93727	93727	93727
Denominator	850	850	157801	157801	157801
Data Source				CSHCN	CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Division of CSHCN staff at both the regional and state levels continued to work closely with Family Connection, SC's parent to parent support organization. Each quarterly meeting for the DHEC CSHCN regional program managers started with an update from the Executive Director of Family Connections. State level CSHCN staff assisted with planning of the annual Family Connection Conference for CSHCN families and providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish broad based advisory group including parents				
2. Provide information, advocacy, and education for parents, families, and providers				
3. Develop and implement treatment plans in consultation with families				
4. Prioritize the resources, needs, and infrastructure within the Division of CSHCN				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Division of CSHCN continues to support parent involvement in all levels of decision making for services for CSHCN. Front-line CSHCN staff is relied upon for their input regarding current expressed needs of these families. Family Connection now has a new email listserv system called eConnection to help get information to CSHCN families and providers as fast as possible. Family Connection staff and other parents of CSHCN participated in the CSHCN focus group for the 2010 Needs Assessment.

c. Plan for the Coming Year
Division of CSHCN will continue to work to involve families of CSHCN in all levels of decision-making. For the five-year planning period beginning July 1, 2010, an objective for Division of CSHCN related to performance measure 2 is: establishing a broad-based advisory group including subcommittees for parent services and Camp Burnt Gin.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	95	95	95	95
Annual Indicator	83.5	83.5	50.6	50.6	50.6
Numerator	710	710	79820	79820	79820
Denominator	850	850	157801	157801	157801
Data Source				CSHCN	CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	55	55

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
DHEC CSHCN and MCH staff participated in the January 2010 SC AAP CATCH Conference to promote the use of and access to medical homes. The above data indicates that slightly more than half of the CSHCN in SC receive health care that meets the AAP definition of medical home. Families of CSHCN in SC report this level of care is more difficult to obtain in rural areas (53%) of SC than in urban (56%) areas.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to expand medical home partnerships				
2. Educate parents on the importance of a medical home				
3. Prioritize the resources, needs, and infrastructure within the				

Division of CSHCN				
4. Increase the number of children served in a medical home				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Division of CSHCN continues to work closely with our state parent-to-parent organization (Family Connection) to promote medical home activities for CSHCN; state level CSHCN staff participate in the quarterly DHEC Commissioner's Pediatric Advisory Committee meetings to provide direct input on medical home services for CSHCN; Local, front-line CSHCN staff in the DHEC administrative regions serve as resources for families of CSHCN for locating medical homes and specialty care providers.

c. Plan for the Coming Year
Regional and state level CSHCN staff will continue to promote the use of AAP defined medical homes for CSHCN. The DHEC Pediatric Advisory Committee will be used to obtain input and provide feedback on medical home issues specific to CSHCN. DHEC CSHCN and MCH staff will continue to participate in the annual SC AAP CATCH Conference.

Division of CSHCN will also continue as a major funding source for medical and related services for CSHCN with a range of medical conditions through the Children's Rehabilitative Services (CRS) program.

For the five-year planning period beginning July 1, 2010, some objectives for Division of CSHCN related to performance measure 3 are: update all policies and procedures related to DHEC services for CSHCN; and increased use of data system information for program planning and evaluation.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	90	90	90	90
Annual Indicator	91.4	91.4	60.1	60.1	60.1
Numerator	12286	12286	94845	94845	94845
Denominator	13438	13438	157801	157801	157801
Data Source				CSHCN	CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Medicaid managed care continued to expand in SC. As of June 30, 2008 (SFY 2008) over 200,000 Medicaid recipients received coordinated care through a traditional Managed Care Organization (MCO) and over 100,000 Medicaid recipients received coordinated care through a Medical Home Network (MHN). Regional and state level CSHCN staffs continue to assist Medicaid recipients in navigating care through this new managed care system. As of June 1, 2010, Division of CSHCN had contracted with one of the SC Medicaid MCO providers to provide audiology durable medical equipment to their enrollees under age 21 years old.
Expansion of SCHIP in SC, began in May 2008, to serve uninsured children whose family income falls between 150-200% of Federal Poverty Level (FPL). Healthy Connections Kids is the new "stand alone" SCHIP program in SC. These enrollees are part of a coordinated care plan that offers the same benefits as the SC State Health Plan for government employees, plus dental and vision care. To be eligible, participants must be uninsured for at least three months to prevent "crowd out", the practice of individuals dropping private insurance in order to receive state assistance.

Division of CSHCN, Children's Rehabilitative Services (CRS) program continues to serve as a major funding source for medical and related services for uninsured and under-insured CSHCN less than age 18 years old whose family income falls under 250%. Expenditures for SFY 2009 exceeded 3.5 million dollars. (SFY 2008 exceeded 4.3 million dollars).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify, refer, and assist families of children with special needs in obtaining Medicaid or other payment sources				
2. Help secure adequate remimursement for providers witha focus on sub-speciality pediatric care				
3. Work with Medicaid Managed Care and other 3rd party insurers maximize benefits for CSHCN				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Local CSHCN staffs continue to refer families of CSHCN to Medicaid and SCHIP programs. The CRS program continues to provide "gap filling" cost coverage for specialty medical care for CSHCN less than 18 years old meeting medical and financial eligibility requirements (family income falls below 250% of the FPL).

c. Plan for the Coming Year
Division of CSHCN will also continue as a major funding source for medical and related services for uninsured and under-insured CSHCN through the Children's Rehabilitative Services (CRS) program. DHEC will continue to work closely with SC Medicaid and SCHIP programs to assure the needs of CSHCN are being met within these systems of care. Monitoring of changes in insurance coverage for CSHCN made possible by the American Recovery and Reinvestment Act (ARRA) of 2009.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	80	80	85	85
Annual Indicator	76.5	76.5	59.8	59.8	59.8
Numerator	828	828	94339	94339	94339
Denominator	1082	1082	157801	157801	157801
Data Source				CSHCN	CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	65

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

A few CSHCN clinic-based, direct care services continue to be offered in areas of SC where a partnership exists with pediatric specialty providers and DHEC. These direct care partnerships work to fill gaps in the pediatric specialty care service delivery system. The DHEC CSHCN staffs usually provide assistance to the specialty physician provider through in-kind space or clinic support staff.

Division of CSHCN continues to partner with the three genetic centers in SC to offer access to genetic consultation across the state.

CSHCN staffs located in the eight DHEC administrative regions across the state, provide the first line of resource assistance for families and service providers of CSHCN in the local areas. Care coordination (assistance with identifying and obtaining needed health care services, beyond information and referral) is provided as needed to CSHCN as resources permit.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue tertiary and medical home partnership developments				
2. Refine case management through Medical Homes				
3. Prioritize the resources, needs, and infrastructure within the Division of CSHCN				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Regional CSHCN office staff continue to provide information and referral assistance upon request of any family member or provider. Care coordination is provided as staffing resources allow and availability of this service varies across DHEC administrative regions.

c. Plan for the Coming Year

The impact of health insurance reform for the CSHCN population in SC will be monitored to identify new or changing gaps in services. Regional CSHCN staff will continue to provide information and referral assistance in their local communities.

For the five-year planning period beginning July 1, 2010, some objectives for Division of CSHCN related to performance measure 5 are: expansion and standardization delivery of care coordination services provided with and through children's hospitals; and standardization of CSHCN staff and capacity in offices maintained in each DHEC administrative region.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	92	92	94	94
Annual Indicator	90.0	90.0	41.4	41.4	41.4
Numerator	974	974	22093	22093	22093
Denominator	1082	1082	53358	53358	53358
Data Source				CSHCN	CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
Regional and staff CSHCN staffs work to identify resources to facilitate an effective transition to adult health care. The need for transitional care from pediatric to adult services was highlighted as part of the annual Family Connection conference for families and providers of CSHCN. One of the regional children's hospitals is starting a transitional care unit for older teenage CSHCN. The goal is for the specific needs of hospitalized young adults with special needs will be addressed in a more efficient and effective manner.

The September 1, 2008 elimination of CRS coverage for clients over age 18 years old greatly

impacted the availability of financial assistance for specialty medical care for this age group. Regional and state level CSHCN staff struggle with identification of resources to fill this gap and assist with transition to financial assistance for ongoing specialty medical care.

Camp Burnt Gin, a residential summer camp for CSHCN in SC, continued to serve approximately 400 campers in the summer of 2009. Specific camp sessions are available for teenagers and young adults with special health care needs. These sessions focus on the needs specific to these age groups and include a variety of information related to transition to adult life.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Improve inter-agency collaboration related to transition care				
2. Prioritize the resources, needs, and infrastructure within the Division of CSHCN				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The September 1, 2008 elimination of CRS coverage for clients over age 18 years old remains in effect due to current budget limitations. This reduction of specialty medical care coverage for this age group shortens the time available to develop a successful plan for transition to adult care.

Camp Burnt Gin continues to provide a residential summer camp experience for CSHCN in SC for the summer of 2010.

c. Plan for the Coming Year

For the five-year planning period beginning July 1, 2010, some objectives for Division of CSHCN related to performance measure 6 are: establish a broad-based advisory group including subcommittees for parent services and Camp Burnt Gin; update all policies and procedures related to DHEC services for CSHCN; and increased use of data system information for program planning and evaluation.

Division of CSHCN will continue efforts to increase coordination of transition services for CSHCN across all agencies and community partners.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	85	90	90	90	90
Annual Indicator	81.7	81.7	81.6	79.1	78.8
Numerator	91431	94000	97920	96502	96333
Denominator	111910	115000	120000	122000	122250
Data Source				Immunization	Immunization
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	85	85	85	85

Notes - 2008
2007 data has been finalized

Notes - 2007
2006 data has been finalized

a. Last Year's Accomplishments
Vaccines impact the daily lives of people and provide young children the best chance for a healthy beginning. SC DHEC and the immunization partnership worked hard through prolonged Hib vaccine shortages and CDC allocations of other vaccines. Providers in the medical home tirelessly reminded parents that yes, Hepatitis B vaccines really are still important. The work of strong anti-vaccine groups were mitigated by even more determined health care professionals who are passionate about protecting children from deadly vaccine-preventable diseases. Educational materials were reviewed and updated to assure the most current informational resources for both the provider and the parent. April 2009 National Infant Immunization emphasis focused on helping all to better understand a very complex childhood immunization schedule.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Regionally, assist private providers in tracking infants and young children who are delinquent in primary immunization series		X		
2. Health departments track infants who are delinquent in primary immunization series		X		
3. Health departments utilize WIC clinics to discuss with mother importance of up to date immunizations for their infant		X		
4. Scheduled July 2010 Statewide Immunization Workgroup meeting with both DHEC and private MD office staff – focus on best practice for immunization administration during well child check-ups.		X		
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b. Current Activities
The Immunization Division is currently working with the SC Hospital Association and Medicaid to cocoon newborns and infants, too young to receive an initial DTaP vaccination, against pertussis disease. A task force has been formed to address Tdap protocol for postpartum areas, educating the mother concerning her infant's risk for pertussis disease and offering Tdap vaccination to these mothers prior to hospital discharge.

The Immunization Division, working with CDC, is utilizing messages to inform parents about the benefits of fully immunizing their young children to protect against life threatening diseases. A June 16th Statewide Immunization Workgroup meeting will be held in Columbia to update immunization staff in both DHEC health departments and private provider offices.

c. Plan for the Coming Year
The Immunization Division will implement a statewide coverage survey for 19-35 month olds assessing for the full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

The Immunization Division will maintain continued emphasis on age appropriate, up to date time adherence to the ACIP recommended childhood immunization schedule. The need for enhanced reminder/recall efforts in SC DHEC Regions will be supported by newly hired Disease Intervention Specialists serving in a tracking role and assisting with provider quality assurance visits at which time office coverage levels are assessed.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	26	26	25	25	24
Annual Indicator	28.1	28.9	27.3	26.8	26.8
Numerator	2469	2681	2540	2519	2519
Denominator	88020	92610	93198	94091	94091
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24	24	24	24	24

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2007
2007 birth file is not available

a. Last Year's Accomplishments

The SC teen pregnancy rate for 2007 for the 15-17 year olds was 36.5 per 1,000, which is a slight decrease from the rate of 37.7 in 2006. The overall teen pregnancy rate (10-19) has increased from 33.1 to 36.5 over the same time period; with the rate for black teens going from 41 to 47.8 and white teens from 27.8 to 29.4. The pregnancy rates for teens have increased statewide in 34 of the 46 SC counties. The SC DHEC family planning clinics continue to prioritize our teen clients and make appointments available to meet the teen's needs. As a result of these efforts, we have seen an increase in the continuation rates for our teens. The continuation rates for the under 15 year olds was 94% for FY 2008 and rose to 99% for FY 2009. For the 15-17 year olds the continuation rate was 89% for FY 2008 and rose to 96% in FY 2009.

The teen clinic on John's Island (Charleston county) is open and seeing a caseload increase monthly. The other teen clinics were operating in Spartanburg, Richland, and Sumter Counties. SC DHEC has continued to partner with The SC Campaign to Prevent Teen Pregnancy. Through this partnership we have been able to embark on a media campaign directed at the teen population, including PSA's, website representation with information and linkages to clinics all over the state. We have also been able to coordinate multiple trainings for staff and community partners specifically designed to reach the teen population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote awareness through media campaigns, health fairs, and health care providers with the Teen Pregnancy Prevention Campaign			X	
2. Initiate a youth development project in at least one new county			X	
3. Collaborate with schools and community groups to provide support services in addition to clinical services.				X
4. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs				X
5. Leverage resources and build partnerships				X
6.				
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b. Current Activities

SC DHEC is currently working to increase access for family planning services. A workgroup, with representation from all the health regions, the Bureau of Maternal Child Health, Women's and Children's Services, the Office of Performance Management, and the Office of Nursing, is working to create a target caseload for each region of the state. The caseload target project should be completed by July 1, 2010. Each region has implemented efficiency recommendations to combat the loss of staff occurring as a result of state budget cuts. The efficiency plan has been a major part of the effort to increase the statewide family planning caseload.

The teen clinics in Charleston, Spartanburg, Richland, and Sumter Counties continue to serve the teens.

c. Plan for the Coming Year

The SC DHEC caseload workgroup will continue to work with the regions to improve clinic efficiencies to make more services available to more clients and make the teen population a priority. Also we will continue to encourage flexible hours for clinic appointments in all our clinics, and especially in our teen clinics.
DHEC is committed to continuing our partnership with The SC Campaign to Prevent Teen Pregnancy to decrease the birth rates in teens. We plan to work on new marketing materials especially created to appeal to the teens and increase their knowledge of our family planning clinics. We are also involved in collaborative grant applications at central office and in the regions that will help increase our capacity to serve this population.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	40	45	50	50
Annual Indicator	37.2	38.6	23.7	23.7	23.7
Numerator	1676	7594	629	629	629
Denominator	4506	19699	2657	2657	2657
Data Source				MCH	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	30	30	30	30	30

Notes - 2009
Data are only collected every 5 years. The Division of Oral health will conduct another needs assessment in 2012.

Notes - 2008
Data are only collected every 5 years. The Division of Oral health will conduct another needs assessment in 2012.

Notes - 2007
Data provided for the years 2003, 2004, 2005, and 2006 were estimates based of the 2002 oral health needs assessment. The Division of Oral Health conducted another needs assessment in 2007. The 2007 data is lower than previous years data; however, the 2007 numbers more accurate. The formula for providing estimates in between needs assessment years will be examined for accuracy in upcoming years.

a. Last Year's Accomplishments
The DOH conducts an oral health needs assessment regarding sealant applications for third grade children every five years with the last one being conducted in 2007-2008. In 2008 the percentage of third grade children who received sealants was 24%. Until the next needs assessment, we can report on the total number of children serviced by the School Dental Prevention Programs (SDPP) that received sealants. Last year 7,946 children served by the five SDPPs with a DHEC Memorandum of Agreement received dental sealants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with organized dentistry, hygienists and local schools to build partnerships that will secure oral health services.				X
2. Develop and provide data tools that will help collect and standardize this data.				X
3. Leverage resources and build partnerships through activities such as the Quarterly Advisory Summits.				X
4.				
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b. Current Activities

The DOH coordinates the public-partnership to provide preventive sealants. Currently there are five SDPPs in the state that provide services in all eight DHEC regions. DHEC provides technical assistance, conducts site visits, annually updates the SDPP manual and MOAs, and provides an annual training for the SDPPs to support program infrastructure and services.

c. Plan for the Coming Year

The DOH will continue to coordinate the public-private dental program by providing technical assistance, collecting data quarterly, and monitoring MOA compliance. DHEC will also continue to provide annual training.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	3.6	3.6	3.6	3.5	3.5
Annual Indicator	5.8	5.1	5.3	5.3	5.3
Numerator	49	43	46	46	46
Denominator	847606	850790	870430	870430	870430
Data Source				Injury Prev	Injury Prev
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.5	3.5	3.5	3.5	3.5

Notes - 2009

2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
2008 data reflect provisional estimates based on 2007 figures.

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2008.

a. Last Year's Accomplishments
During the 2007/2008 grant cycle from October 1, 2008 -- September 30, 2009, DHEC Division of Injury and Violence Prevention (DIVP) established twelve safety seat fitting stations. Child Passenger Safety Instruction was provided to 197 technicians. Eighteen 32-hour National Standardized Child Passenger Safety Training Classes were conducted. Staff also conducted 62 child safety seat inspection events and participated in outreach efforts to the Hispanic/Latino Community. In addition, DIVP staff distributed 585 convertible car seats and 191 booster seats, and participated in six community outreach events. DIVP also provides child injury prevention education and technical assistance to communities and organizations across the state upon request and referral.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide public education on the seatbelt and child restraint laws and best practices.		X		
2. Increase local capacity for child passenger safety through training of certified Child Passenger Safety Technicians.		X		
3. Provide technical assistance and CPS program supplies to state and local partners.				X
4. Leverage resources and build partnerships at the state and local levels to increase CPS programs capacity statewide.				X
5.				
6.				
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b. Current Activities
During the current grant cycle from October 1, 2009 -- March 31, 2010, DHEC Division of Injury and Violence Prevention (DIVP) established one safety seat fitting station. Child Passenger Safety Instruction has been provided to 83 technicians. Eight 32-hour National Standardized Child Passenger Safety Training Classes have been conducted. Staff also have conducted eighteen child safety seat inspection events and continue to participate in outreach efforts to the Hispanic/Latino Community. In addition, DIVP staff has distributed 281 convertible car seats and 56 booster seats. DIVP also continues to provide child injury prevention education and technical assistance to communities and organizations across the state upon request and referral.

c. Plan for the Coming Year
During the grant cycle from October 1, 2010 -- September 30, 2011, DHEC Division of Injury and Violence prevention will continue core program activities including providing public education on the seatbelt and child restraint laws and best practices, increasing local capacity for child passenger safety through training of certified Child Passenger Safety Technicians, providing

technical assistance and CPS program supplies to state and local partners, and leveraging resources and building partnerships at the state and local levels to increase CPS programs capacity statewide.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		60	61	65	65
Annual Indicator	56.5	38.6	37.1	37.1	37.1
Numerator	32837	21335	20600	20600	20600
Denominator	58120	55279	55591	55591	55591
Data Source				PRAMS	PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	42	42	42	42	42

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
2006-2008 PRAMS, which ascertains breastfeeding information at 10 weeks. Previous data reflected breastfeeding at birth.

Notes - 2007
Data reflects 2007 PRAMS,which ascertains breastfeeding information at 10 weeks. Previous data reflected breastfeeding at birth.

a. Last Year's Accomplishments
Each Region maintains breastfeeding peer counselors to provide one-on-one breastfeeding support and education to WIC participants. The education started during pregnancy, and the support would continue through the post partum period.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand the breastfeeding peer counselor program		X		
2. Improve accuracy of collecting WIC breastfeeding data				X
3. Provide training to Regional staff about data input, cultural sensitivity, and the use of peer counselors				X
4. Prioritize the resources, needs, and infrastructure of MCH Bureau and its programs				X
5. Leverage resources and build partnerships				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities
Funding for peer counselors was increased through the USDA Loving Support funds, which allowed expansion of the WIC Peer Counseling Program. Currently, women are able to access the peer counseling services in the health department clinics. Unfortunately, some barriers exist that have affected participation. Barriers such as transportation to the clinics as well as long wait times in clinics, due to reduced staff, have decreased participation in breastfeeding education both in group settings and one-on-one peer counseling.

c. Plan for the Coming Year
In the coming year, WIC will provide frequent contacts to pregnant women who have decided to breastfeed, focus on face-to-face contact in the home during the last trimester of pregnancy, visit WIC breastfeeding moms in the hospital and assure breast pumps are available upon request.

There will be more in depth training for peer counselors in order to provide the counselors with the knowledge to explain proper position and latch for newborn as well as to recognize any risk factors that would interfere with breastfeeding, such as breast engorgement. Having this knowledge and recognizing these signs would help with continuation of breastfeeding past 6 months. The peer counselors will also be able to make appropriate and necessary medical referrals in a more timely manner.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	99.5	98.7	97.9	90.1	90.1
Numerator	53812	58221	58573	53532	53532
Denominator	54080	59000	59808	59424	59424
Data Source				MCH	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008

With the transition to the new data system, we have seen an expected, temporary, drop in hearing screeen reporting as hospitals get used to the new reporting process that requires them to perform data entry rather than relying on batch files. Reports have been written to identify those babies whose hearing screen has not been reported, and is currently being sent to their respective hospitals.

a. Last Year's Accomplishments
In 2009, First Sound made great progress in streamlining its fragmented data into one system that is linked with the Electronic Birth Certificate of the Vital Records system. The new data system is called the Birth Data Exchange Engine (BEE) and will soon incorporate screening, follow-up, and early intervention data systems which currently are spread across four different databases. Because of our tremendous progress towards data integration, First Sound was invited by the CDC to participate in an expert panel for data integration.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. South Carolina hospitals report all newborn hearing screen results to the First Sound Program.				
2. If the newborn fails the screen the hospital is responsible for referring the baby to an audiologist for additional testing and reporting the referral to the First Sound program.				
3. The First Sound program follows all referred babies until a final outcome is documented by the Audiologist.				
4. When appointments are missed a referral to the regional staff to assist in getting the infant reappointed and to reinforce the importance of hearing on development and future academic success.				
5. The follow-up coordinator also sends letters to the parents for additional reinforcement.				
6. A letter is sent to primary care provider to enlist their support for multiple missed appointments and/or a diagnosis of permanent hearing loss.				
7.				
8.				
9.				
10.				

b. Current Activities
First Sound continues to work on completing the integrated data system. Completion of the system is the foundation for working towards future goals. First Sound is also working towards re-establishing a connection with the state Part C program after their move to the SC First Steps agency.

c. Plan for the Coming Year
First Sound will continue to work on the integrated data system by addressing any issues that arise from the release of the first two phases and implementation of the last Phase. First Sound will also continue efforts in establishing a parent support network specific to deaf and hard of hearing children. First Sound also plans to use the new integrated data system to create report cards for hospitals and audiologists to provide better feedback to stakeholders.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	8	8	7	7
Annual Indicator	10.7	10.7	10.7	12.8	12.8
Numerator	109000	110500	112000	137000	137000
Denominator	1016000	1029000	1042000	1070000	1070000
Data Source				ORS	ORS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	9	9	9	9	9

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
source

http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=39&rgn=42

Notes - 2007
Data obtained from the U.S. Census, Current Population Survey, Annual Social and Economic Survey 2007

a. Last Year's Accomplishments
South Carolina's high unemployment rate also contributed to the increased number of eligible children. Children received coverage through Medicaid and SCHIP stand alone (150% to 200% of poverty) statewide. Due to budget cuts caused by the downward trend in the economy, the Medicaid budget did not allow for expanding eligibility thresholds. The number of Medicaid children increased approximately 20,000 from January 2009 to January 2010. The number of SCHIP stand alone children increased from 13,559 in May 2009 to 15,529 in May 2010. This increased enrollment was lower than anticipated. However, need continues to outpace enrollment.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Nurture existing partnerships and develop new partnerships to ensure an adequate workforce to serve children in a coordinated system of care.				X
2. Engage partners/participate in quarterly meetings to discuss/ensure coverage of Medicaid and low-income children.				X
3. Educated legislators, Medicaid Agency and other advocates about expanding benefits and eligibility for Medicaid and SCHIP.				X

4. Leverage and build partnerships.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DHEC continues to collaborate with Medicaid and the five Medicaid managed care organizations. Medicaid provides quarterly updates on enrollment and expansion at task force meetings. Although the final budget for Medicaid for FY 11 has yet to be finalized, it will not allow for the anticipated 10% expansion, and currently the legislature is considering terminating enrollment for the SCHIP stand alone program. The Care Line continues to assist with SCHIP stand alone awareness activities by providing information upon request. Information on Medicaid and SCHIP stand alone is available in county offices and CSHCN staff provide information and assistance to families.

c. Plan for the Coming Year

DHEC will continue to work with Medicaid, Medicaid Managed Care, and other entities to ensure that children receive services. Medicaid will continue to be involved with quarterly task force meetings. Staff will continue to assist with Medicaid utilization and eligibility referrals.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		28	28	28	28
Annual Indicator	42.1	100.0	4.2	35.0	35.0
Numerator	35313	1	35313	29209	29209
Denominator	83791	1	837910	83487	83487
Data Source				MCH	MCH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	28	28	28	28

Notes - 2009

2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008

WIC data are provided by CDC with two years' time lag for data processing. We are awaiting 2008 data for entry from the CDC. A placeholder will be used for 2009 data.

Notes - 2007

WIC data are provided by CDC with two years' time lag for data processing. We are awaiting 2006 data for entry from the CDC. Final data for 2007 will not be provided until 2009. A placeholder will be used for 2007 data.

a. Last Year's Accomplishments
The new WIC food packaging was implemented. The new food package allows WIC participants to choose healthier options, which can contribute to improvements in this particular indicator. The implementation of the new food package was intensive and required a significant amount of staff and participant education. Despite the monumental change, the transition went relatively smooth.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Build capacity in the state by focusing on policy and environmental support changes, disseminating best practice information and proving technical assistance				X
2. Increasing availability and access to pilot nutrition education classes.		X		
3. Prioritize the resources, needs and infrastructure of the MCH Bureau and its programs				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A Registered Dietitian (RD) in one of the SC DHEC regions has created a weight management/nutrition education class, which is to be taught by a RD. This class provides nutrition counseling for the mom and child in a group setting. The program has exhibited success in the original pilot region. The program has been evaluated by taking weights and heights, assessing physical activity, and change in nutrition habits.

Current issues surrounding the undocumented immigrant population are also arising. It seems that this population is opting not to participate in the WIC program for fear of health department raids or being reported. Increased education about the program may be necessary to reach this population.

c. Plan for the Coming Year
Evaluate the acceptance of the food packaging changes by participants. Understanding the acceptance will better help the WIC program explain to participants the benefits of the new food packaging. Overall, fewer WIC dollars have been utilized, and there is concern that the current economy has created a dilemma for the participants. A choice must be made to find transportation to receive WIC vouchers, but if the food packaging is not appealing to the clients, they may choose to decline. For this reason, evaluation of the new food packaging is necessary.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		10	10	10	10
Annual Indicator	11.7	11.3	9.5	9.6	9.6
Numerator	6413	7003	5903	6039	6039
Denominator	54663	62187	62316	63077	63077
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	10

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2007
2007 birth file not available

a. Last Year's Accomplishments
The Division of Tobacco Prevention and Control continues to promote cessation among all of SC's citizens, but has a significant interest in quitting among pregnant women. Over the past year, additional funds have been received from both the March of Dimes and ARRA to address this special population. As a result, the Division has enhanced services to pregnant women through multi-call intervention with the SC Tobacco Quitline and work for the adoption of a DHEC agency policy to ask, advise and refer (2As+R) all clients who utilize clinical services. This policy was adopted in November 2009 and will be fully deployed July 1, 2010.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Promote 2As+R online training to prenatal providers statewide.				X
2. Place television and radio advertisements promoting quitting among pregnant women and encouraging use of the SC Tobacco Quitline.			X	
3. Maintain multi-call Quitline services for SC's pregnant population.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Currently, the Division is continuing work to increase the number of pregnant women who make a quit attempt utilizing evidence-based services. This includes continued promotion through providers of the "Ask, Advise and Refer" policy (2As+R), as well as TV and radio advertisements specifically targeting the pregnant population.

c. Plan for the Coming Year
In the coming year, the Division will continue the current activities above, including further promotion of the 2AS+R policy through a newly-launched online Continuing Medical Education (CME) credit training (November), TV and radio ads, and, specifically in our two newly-funded Communities Putting Prevention to Work projects, GIS mapping of community "hotspots" where women report smoking during pregnancy will be targeted for enhanced provider education and encouragement of the 2As+R policy. The intended outcome is to increase the utilization of the SC Tobacco Quitline by pregnant women in these communities through encouragement by their prenatal provider.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	5.5
Annual Indicator	6.7	6.3	3.8	3.8	3.8
Numerator	20	20	12	12	12
Denominator	300380	315050	318280	318280	318280
Data Source				Injury Prev	Injury Prev
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	3	3	3

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
2008 data reflect provisional estimates based on 2007 figures.

Notes - 2007
This information is unavailable from PHSIS because they have not been able to close the 2007 death file at this time. We hope to have the data by August 2009.

a. Last Year's Accomplishments
MCH and Community Health and Chronic Disease Prevention Bureau staff continue to be key members of the SC Suicide Prevention Coalition. A data dissemination workshop sponsored by the DHEC Division Injury and Violence Prevention (DIVP) was held in August 2008 and included data related to suicide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue work of the statewide coalition to address suicide prevention issues.				X
2. Hold a data dissemination workshop to include data related to violent deaths				X
3. Leverage resources and build partnerships				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Coalition has produced the South Carolina's Suicide Prevention brochure and distributed it through multiple partner organizations. Funding for the brochure project was blended from the SC AFSP Chapter, Mental Health America of SC, SC DHEC Division of Injury and Violence Prevention, and other partners. A data dissemination workshop sponsored by DHEC DIVP was held in August 2009 and included a special plenary session related to survivors of suicide with a focus on exposure to suicide in childhood.

c. Plan for the Coming Year

1. Update, print and disseminate the State Suicide Prevention Plan, which was originally developed in 2005, to include strategies and objectives for 2010 to 2015.
2. Finalize, print, and disseminate a Youth Violent Death report.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	80	82	84	84	86
Annual Indicator	77.4	78.5	71.9	73.9	73.9
Numerator	878	864	931	873	873
Denominator	1134	1100	1294	1181	1181
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014

Annual Performance Objective	75	80	80	80	80

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
2008 birth file not available

Notes - 2007
2007 birth file not available

a. Last Year's Accomplishments
Perinatal Regionalization continues to remain strong and intact as a system in South Carolina. This has been a great accomplishment despite the budget cuts that were experienced in 2008/2009. Regional staff was able to continue providing the necessary outreach education, community involvement and monitoring of transport/transfer information and data to ensure pregnant women and neonates received the appropriate level of care.

All required annual meetings between Regional Perinatal Centers and outlying hospitals were conducted and all Memorandums of Agreement executed. Every hospital reviewed their VLBW tools with their regional staff and experts to discuss system issues. Each regional staff prioritized their level of community involvement and participated in FIMR activities, health department projects, national committee involvement and all maintained their work with the SC March of Dimes and the South Carolina Perinatal Association. Much work went into coordinating with the Ob Task Force, the development of a Maternal Fetal Medicine Coalition and Medicaid to ensure that the Medicaid HMOs financially support the regionalized system of care established in South Carolina including backtransporting of infants. This remains an ongoing effort and the MCH Bureau has taken on leadership to ensure our most vulnerable continue to receive care regardless of payor source.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Perform Outreach Education to regional and rural hospitals; health departments; community agencies based on annual Regional Needs Assessment				X
2. Establish partnerships with community agencies to ensure services are provided for pregnant women and infants				X
3. Review all VLBW infants that are born outside of a Regional Perinatal Center (LIII) with expert staff from the Regional Centers and outlying hospitals				X
4. Participate in all Fetal Infant Mortality Review process groups throughout the state				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Routine operations were limited due to decreased funding. However, outreach education staff statewide developed creative ways to educate and reduce travel efforts. Neonatal Resuscitation

Programs, STABLE, and Fetal Monitoring were all still taught to hospitals all across SC to ensure hospital personnel remained current on their skill sets. Regional Systems Developers continued to provide leadership and monitoring of systems of care to maintain appropriate referrals to Regional Perinatal Centers so high risk obstetric patients and high risk infants received the appropriate level of care.

With the Maternal Fetal Medicine Collaborative, the Regional staff worked to ensure funding was maintained for patient care as well as regionalization efforts. In addition, regional staff worked with the statewide Neonatal Consortium on their quality improvement efforts in implementing the "golden hour" for neonates. This work continues with educational offerings being developed from this work.

c. Plan for the Coming Year

The MCH Bureau has been able to hire a Perinatal Programs Coordinator to assist in continuing to monitor, develop, and sustain SC's successful regionalization program. Possibly due to the recession, many SC hospitals have seen a decline in their overall delivery rates and have administrators scrambling to try and address the economic impact. This downward trend also impacts the financial viability of many of our rural hospitals. Therefore, the need for a cohesive, intact regionalization program is extremely important. When physicians/hospitals are paid more for a delivery than the prenatal care that is provided, hospitals may try and find ways to keep as many deliveries as possible versus sending to a Perinatal Regional Center for the actual delivery, with the infant being transported at the time of birth. It is our plan to maintain our program and find ways increase sustainability and the integrity of our programming providing oversight, education, and assistance in addressing these systems issues.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	74	76	80	90
Annual Indicator	69.3	67.2	68.6	69.0	69.0
Numerator	39889	41778	43159	43512	43512
Denominator	57538	62187	62933	63077	63077
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	75

Notes - 2009

2009 Birth File not available

Notes - 2008

2008 Birth File not available

Notes - 2007
2007 birth file not available

a. Last Year's Accomplishments
The Nurse Family Partnership program was launched in several regions across the state. This program was implemented to assure that participants in the program receive early and adequate prenatal care. The County Health Departments continued to refer women with positive pregnancy tests to prenatal care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer patients with positive pregnancy tests to prenatal care providers, and execute appropriate follow-up to ensure early entry into care	X			
2. Educate through the Caring for Tomorrow's Children Program.		X		
3. Leverage resources and build partnerships				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
South Carolina continues to address barriers to accessing prenatal care, including Medicaid enrollment, cultural beliefs, and general awareness of its importance. The PASOs program has positively impacted the adequacy of prenatal care for Latina women, and it has been able to expand into other areas of the state. Additionally, support is being given to programs encouraging and/or providing prenatal care services, such as the Nurse Family Partnership.

In conjunction with the Office of Performance Management, MCH is working with selected regions on Prenatal Care Quality Improvement initiative related to entry into prenatal care. Two regions with multiple teams from WIC and Family planning are participating in the project. Certain aspects of the project are devoted to improve internal referral systems for both Family Planning and WIC in an effort to improve trimester of entry into prenatal care.

c. Plan for the Coming Year
Work with Medicaid and Managed Care Organizations will continue in order to improve early access to prenatal care. The Commissioner's OB Task Force continues to address issues that inhibit early and adequate prenatal care. Additionally, results of a Prenatal Care Quality Improvement initiative will be released in the coming year. The results of the initiative will hopefully give insight to methods to improve the way patients are referred for prenatal care, prenatal care service delivery, as well as prenatal care data collection.

D. State Performance Measures

State Performance Measure 2: *Increase the percent of newborns receiving a newborn home visit.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		55	60	60	65
Annual Indicator	40.3	44.2	40.6	35.4	35.4
Numerator	13005	14670	14706	12442	12442
Denominator	32266	33219	36209	35148	35148
Data Source				ORS	ORS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

a. Last Year's Accomplishments
While the provision of high quality PPNBHVs continues to be an agency priority, the agency's capacity to provide visits to Medicaid eligible women and newborns continued to decrease. The goal of eventually providing PPNBHVs to at least 90% of the eligible population, through the combined efforts of DHEC RNs and nursing staff from other home visitation agencies, now seems unrealistic given the many economic challenges faced by the state. The number of Medicaid eligible women and newborns continues to increase because of economic conditions in SC, while the number of RN staff available to provide the visits has decreased because of agency budget cuts. The MCH Bureau published a set of high risk criteria for regions to use when visits must be prioritized. In addition, almost all women and newborns enrolled in Medicaid choose or are assigned to a managed care plan. Not all of the managed care plans offer PPNBHVs to their clients, while those which do often require preauthorizations which are frequently time-consuming to obtain. Regions provide PPNBHVs to high risk families whenever possible, even when their managed care plan will not pay for a visit.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PPNBHVs will continue to be a bureau priority in 2010.				X
2. PPNBHV clients will be referred to a medical home.		X		
3. Technical assistance and consultation with regions will be provided as indicated to assure PPNBHVs continue to be provided in all regions.				X
4. Prioritize the resources, needs, and infrastructure of the MCH Bureau, its divisions, and programs.				X
5. Leverage resources and build partnerships.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Previously, most regions had one or more RNs assigned to each county to make PPNBHVs, but in many areas one RN must provide visits to families in multiple counties now. Regions use the high risk criteria from the MCH Bureau to determine those with the greatest need for a PPNBHV

when staff are limited. With the increased enrollment of families in Medicaid managed care plans, the number of PPNBHVs for which the agency was able to recoup a portion of the visit costs continued to decrease. In state fiscal year 2009, regions reported making 16,203 visits, but billing only 14,174.

c. Plan for the Coming Year
DHEC continues to service as an advocate for providing PPNBHVs to mothers and infants, as well as providing training, infrastructure maintenance, and technical support for PPNBHVs to regions. Negotiations with Medicaid managed care organizations (MCOs) to make PPNBHVs available to mothers and newborns and to simplify the processes for working with the MCOs are ongoing.

State Performance Measure 3: *Increase the number of comprehensive medical home partnerships for pregnant women, children and CYSHCN.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	45	60	75
Annual Indicator					
Numerator	10	10	10	10	10
Denominator	10	10	10	10	10
Data Source				N/A	N/A
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	

Notes - 2009
No data for this indicator

Notes - 2008
No data for this indicator

Notes - 2007
No data for this indicator

a. Last Year's Accomplishments
The availability of medical homes for these populations continued to be a priority. Regional staff continued to foster relationships with medical homes at the local level. DHEC worked with pediatricians through quarterly task force meetings (OB and Pediatric) and the annual Community Access to Child Health (CATCH) meeting. CSHCN staff were involved with the transition of the Medically Fragile Children's Program to a Waiver program. Dr. Rushton, the medical consultant, collaborated with Medicaid and the University of South Carolina to apply for a CHIPRA grant. South Carolina received the grant. Two areas of focus include quality improvement and co-location of services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Work with physicians to specify what is included in collaboration and communication for a continuum of care.				X
2. Work with partners to develop and implement a CQI process.				X

3. Prioritize the resources, needs and infrastructure of the MCH Bureau, its Divisions and its programs.				X
4. Leverage resources and build partnerships.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
DHEC promotes medical homes. Budget cuts decreased DHEC's ability to co-locate services and devote staff time to partnerships. DHEC works with Grennville's Help Me Grow, an initiative to connect/refer children who are identified as at-risk through developmental screenings, but do not meet criteria for Baby Net. Referrals are facilitated through a toll-free line operated by certified staff. The SC Medicaid managed care contracts include quality improvement standards. A nurse care coordinator still works with CSHCN and DHEC works with Family Connection to engage/educate CSHCN parents. DHEC will work with Medicaid and the University of South Carolina on the CHIPRA grant.

c. Plan for the Coming Year
DHEC will continue to work with various partnerships including the CHIPRA grant. DHEC will collaborate to ensure support for the care coordinator position for CSHCN that is now housed under South Carolina Solutions, the Medical Home Network and data will continue to be reviewed from services that the nurse care coordinator providesd.

Collaboration with Family Connection will remain a priority and DHEC CSHCN staff will continue to help families transition to the Medically Fragile Waiver.

State Performance Measure 5: *Decrease the percent of family planning clients served by health departments whose pregnancy was unintended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		45	45	45	45
Annual Indicator	0.0	50.2	44.7	48.3	48.3
Numerator	0	28497	25070	27910	27910
Denominator	1	56806	56039	57758	57758
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45	45	45	45	

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
This is not restricted to family planning clients, but rather representative of all SC resident women having a live birth in SC.

Unintended pregnancies: pregnancies that were wanted later (mistimed) or pregnancies that were not wanted then, or at any time in the future (unwanted).

Notes - 2007
We don't know whether an individual is a family planning client served by health departments. However, we do collect data on pregnancy intention on the general population of SC. This is the data that reflects that surveyed info.

a. Last Year's Accomplishments
SC DHEC has continued to monitor this indicator closely. We are unable to directly enumerate data for this measure; however, the unintended pregnancy rate for the state serves as a proxy measure. The rate is determined from PRAMS data; therefore, fluctuations from year to year are expected. However, approximately half of pregnancies in South Carolina are unintended. DHEC was committed to continuing the downward trend of unintended pregnancies by focusing on the statewide caseload in family planning. In 2007 the statewide caseload was 94,916, which decreased in 2008 to 92,374, but then increased in 2009 to 99,136. This was a 7% increase in one year. The caseload increase was accomplished, in part, by the formation of a statewide workgroup, with representation from all the health regions, the Bureau of Maternal Child Health, Women's and Children's Services, the Office of Performance Management, and the Office of Nursing.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This will not be a priority in the upcoming cycle in it's current form; therefore, no activities are reported				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The established group is continuing work to create a target caseload for each Region of the state. Each region will be focus on implementing the efficiency recommendations as an effort to combat the loss of staff occurring as a result of state budget cuts. The efficiency plan has been a major part of the effort to increase the statewide family planning caseload.

c. Plan for the Coming Year
Increasing the family planning caseload is an agency priority; therefore, work surrounding this performance measure will continue. Loss of overall staffing capacity due to the ongoing state budget cuts will create a challenge for sustaining progress related to this indicator. Work will continue to improve clinic efficiency sustain the current level of service provided.

State Performance Measure 6: *Increase the number of MCH programs that utilized research findings to better target programs to vulnerable populations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		40	50	60	70
Annual Indicator	30.3	34.3	34.3	34.3	34.3
Numerator	10	12	12	12	12
Denominator	33	35	35	35	35
Data Source				N/A	N/A
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	80	80	80	

Notes - 2008
No clear means of collecting this information. Numbers provided are an estimate.

Notes - 2007
No clear means of collecting this information. Numbers provided are an estimate.

a. Last Year's Accomplishments
During the past year a significant amount of staff time and energy has been devoted to collecting data and information necessary for completion of the 5 year needs assessment. Data was pulled from multiple data sources that include vital records, PRAMS, BRFSS, YRBSS, Kids Count, Medicaid claims, DHEC program data, and qualitative data from key informant interviews and workgroup meetings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This will not be a priority in the upcoming cycle in it's current form; therefore, no activities are reported				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Data from the needs assessment has been compiled and is being used to establish the state priorities and performance measures reflected in this grant cycle. Given the lack of reliable data for the previous year's performance measures, a significant amount of time and efforts has been used to establish meaningful performance measures that will impact all Title V programs.

c. Plan for the Coming Year
This measure in its current form will no longer be a priority area of need for the Bureau. Rather, focus will be placed on building capacity by expanding existing staff knowledge, skills, and abilities related to data analysis and evaluation.

State Performance Measure 7: *Increase the number of health departments who implemented a review process for fetal and infant deaths.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		50	55	60	65
Annual Indicator	45.7	23.9	19.6	34.8	19.6
Numerator	21	11	9	16	9
Denominator	46	46	46	46	46
Data Source				MCH	MCH
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	75	75	75	

a. Last Year's Accomplishments
Efforts to revive more local FIMR teams continued. Partnerships were established with Healthy Start. Specifically, Low Country Healthy Start agreed to assist in conducting Home Interviews; unfortunately inadequate resources within the local health department prevented the FIMR program to continue in the service area of Low Country Healthy Start. Therefore, the home interview services were not utilized. Additionally, plans to implement the state FIMR Database continued.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Target priority issues such as prematurity, safe sleep, shaken baby syndrome, and preconception health			X	
2. Build partnerships with local community stakeholders				X
3. Provide state level technical support and data to alleviate burden of case abstraction, therefore reducing requirement of financial resources at local level for staff				X
4. Seek funding for community program initiatives identified by FIMR Community Action Teams				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current efforts have been directed towards finalizing the state database in order to provide better data to community groups that are making decisions on which programs are implemented at the local level. Within the next year, it is expected that the FIMR Database will be ready for use. The state coordinator is also continuing to provide technical assistance to the local review teams in order to improve competitive status in regards to grant applications for community programs.

c. Plan for the Coming Year
As the state database is finalized, efforts will be targeted at establishing the state review team, facilitating revival and/or establishment of local community action teams, and better integration

and collaboration with local child death review teams so that efforts are not duplicative. The launch of the new FIMR database will also present an opportunity for FIMR to begin releasing an annual report with hopes that the availability of the FIMR data will encourage local communities to revive FIMR case review and community action teams that have been dormant due to budget restrictions. Additionally, partnership with Palmetto Healthy Start has provided a new opportunity for a FIMR process among their clients. This partnership will be important as the community efforts that result from Palmetto Healthy Start's internal review could have an impact on other consumers in the community.

State Performance Measure 8: *Increase the percent of infants who are breastfed at birth and thereafter.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		48	50	53	55
Annual Indicator	56.5	57.3	58.0	59.5	59.5
Numerator	32519	35624	36554	37544	37544
Denominator	57538	62187	62993	63077	63077
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	58	60	60	60	

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
2008 birth file is not available

Notes - 2007
2007 birth file is not available

a. Last Year's Accomplishments
The WIC peer counselor program was initiated in order to provide one-on-one breastfeeding education and support to WIC participants both during pregnancy and post partum. State budget cuts resulted in the reduction in the number of breastfeeding peer counselors, which has affected access to the services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hospitals and the Perinatal Regional Centers will offer educational classes on breastfeeding and the services of a lactation counselor		X		
2. Improve relationship between WIC and hospitals to increase reach of peer counselor program		X		
3. Prioritize the resources, needs, and infrastructure of the MCH Bureau, its Divisions, and programs				X
4. Leverage resources and build partnerships				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Various activities are currently in place to promote breastfeeding. Currently, all WIC staff that provides certification must encourage and provide information about breastfeeding at certification. Unfortunately, barriers exists that conflict with the breastfeeding message that WIC is trying to promote. For example, many formula companies are better able to communicate their message by use of media advertising and coupon offers. It is often difficult to compete with such messages that conflicts with the WIC goal to increase breastfeeding. Anther barrier in South Carolina is general attitude about breastfeeding in the state.

SC DHEC is making progress towards an agency goal, which is to provide a private, comfortable room for breastfeeding employees in each SC DHEC central office building.

c. Plan for the Coming Year
Research an agreement between delivering hospitals and the WIC program to permit visitation by WIC peer counselors to breastfeeding moms after delivery.

Increase participation in the WIC peer counselor breastfeeding program by identifying counselors from the communities with the greatest need as well as allowing the counselors to go out into the community more frequently to deliver services. This would alleviate the transportation barrier that exists for many WIC clients.

State Performance Measure 10: *Increase the percent of pregnant women who are health department clients who are linked and referred for prenatal care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	100	100	100	100	100
Denominator	100	100	100	100	100
Data Source				MCH	MCH
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	

a. Last Year's Accomplishments
There is no change with this indicator. All pregnant women who are health department clients are linked and referred for prenatal care.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue quality improvement process to improve referral system				X
2. Dissimenate results to other regions and clinics				X

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Although all clients are referred, little is done to determine the extent to which women keep referral appointments and how soon after a positive pregnancy test clients follow up with a prenatal care provider. Two DHEC regions are currently working on quality improvement projects to improve entry into prenatal care. These regions are examining these issues and developing/testing interventions to improve the referral process between family planning and WIC clients.

c. Plan for the Coming Year
Quality improvement initiatives will continue and results will be presented. Promising strategies for measuring and improving the internal referral process will be expanded to other regions and clinics statewide.

E. Health Status Indicators

Introduction
The outlined health status indicators are somewhat helpful in directing public health efforts. Some measures are more relevant to Title V programming than others. Certainly measures related to birth weight, unintentional injury/motor vehicle crashes, and sexually transmitted disease are relevant for directing public health efforts and should be included as part of routine surveillance activities. In South Carolina these tend to fall outside the direct leadership of Title V; therefore, are more indirectly related to ongoing program operations. Population demographics can be helpful to a degree but are really used more for background information and are not really appropriate as evaluation measures.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10.2	10.2	10.2	9.9	9.9
Numerator	5895	6313	6401	6239	6239
Denominator	57538	62187	62933	63077	63077
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2007
2007 Birth File has not been released

Narrative:
The percent of live births weighing less than 2500 grams has decreased for the first time in several years. The prevention of low birth weight outcomes remains a significant area of focus for MCH. Efforts to improve the health status of women entering pregnancy and assure access to needed medical care continue. Improving pre-inter-conception health will be a priority for MCH in the upcoming 5 year planning cycle. Increased access to 17P and other advances in medical technologies and procedures extending the gestational period could also be impacting the observed outcome.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.4	8.4	8.3	8.1	8.1
Numerator	4694	5027	5035	4943	4943
Denominator	55703	60106	60783	60954	60954
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2007
2007 birth file is not available

Narrative:
The percent of live singleton births weighing less that 2500 grams also decreased during the past year. As previously noted, efforts to improve the health status of women entering pregnancy and assure access to needed medical care continue. Improving pre-inter-conception health will be a priority for MCH in the upcoming 5 year planning cycle. Increased access to 17P and other advances in medical technologies and procedures extending the gestational period could also be impacting the observed outcome.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	2.1	1.9	2.1	1.9	1.9
Numerator	1195	1158	1294	1181	1181
Denominator	57538	62187	62933	63077	63077
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2007
2007 birth file is not available

Narrative:
The percent of live birth weighing less than 1500 grams decreased slightly during the past year, but remains consistent with ongoing trends. Efforts to improve the health status of women entering pregnancy and assure access to needed medical care continue. Improving pre-inter-conception health will be a priority for MCH in the upcoming 5 year planning cycle. Increased access to 17P and other advances in medical technologies and procedures extending the gestational period could also be impacting the observed outcome.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	1.5	1.7	1.5	100.0
Numerator	915	916	1030	886	1
Denominator	55703	60106	60783	60954	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007
2007 birth file is not available

Narrative:
The percent of singleton live birth weighing less than 1500 grams decreased slightly during the past year, but remains consistent with ongoing trends. Efforts to improve the health status of women entering pregnancy and assure access to needed medical care continue. Improving pre-inter-conception health will be a priority for MCH in the upcoming 5 year planning cycle. Increased access to 17P and other advances in medical technologies and procedures extending the gestational period could also be impacting the observed outcome.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	12.9	13.3	13.9	13.9	13.9
Numerator	109	113	121	121	121
Denominator	844090	850790	870430	870430	870430
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
2008 data reflect provisional estimates based on 2007 figures.

Narrative:
Data available for this particular indicator is at least 3 years behind current programs and initiatives. During this time period, the death rate due to unintentional injuries among children >14 increased slightly from 2006 to 2007. Unintentional injury remains an important area of focus for the Division of Injury and Violence Prevention. The Division maintains programs addressing child passenger safety, residential fire prevention, and leads a child fatality review process. In addition, the Division also maintains an injury surveillance system to determine the magnitude, causes, and risk factors associated with injury. The Division also maintains the violent death reporting system that collects information on violent deaths in South Carolina as part of the National Violent Death Reporting System. This system answers critical questions of when, where, and how violent deaths occur.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	5.8	5.1	5.3	5.3	5.3
Numerator	49	43	46	46	46
Denominator	844090	850790	870430	870430	870430
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
2008 data reflect provisional estimates based on 2007 figures.

Narrative:
The unintentional death rate for childen <14 due to motor vehicle crashes remains consistent with previous years data. DHEC Division of Injury and Violence Prevention (DIVP) established one safety seat fitting station. Child Passenger Safety Instruction has been provided to 83 technicians. Eight 32-hour National Standardized Child Passenger Safety Training Classes have been conducted. Staff also have conducted eighteen child safety seat inspection events and continue to participate in outreach efforts to the Hispanic/Latino Community. In addition, DIVP staff has distributed 281 convertible car seats and 56 booster seats. DIVP also continues to provide child injury prevention education and technical assistance to communities and organizations across the state upon request and referral. Effors to sustain core program activities including providing public education on the seatbelt and child restraint laws and best practices, increasing local capacity for child passenger safety through training of certified Child Passenger Safety Technicians, providing technical assistance and CPS program supplies to state and local partners, and leveraging resources and building partnerships at the state and local levels to increase CPS programs capacity statewide will continue.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	41.4	39.5	41.8	41.8	41.8
Numerator	252	242	259	259	259
Denominator	609060	611950	620320	620320	620320
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2008
2008 data reflect provisional estimates based on 2007 figures.

Narrative:
Data indicates the death rate from unintentional injuries due to motor vehicle crashes among youth aged 15-24 has remained. Unintentional injury remains an important area of focus for the Division of Injury and Violence Prevention. In addition to child passenger safety programs, the DIVP also maintains an injury surveillance system to determine the magnitude, causes, and risk factors associated with injury, including those from motor vehicle crashes. Information gathered provides guidance in developing appropriate strategies for addressing this issue.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	9,363.6	8,917.2	9,158.1	8,583.3	8,583.3
Numerator	79037	75867	79715	75478	75478
Denominator	844090	850790	870430	879360	879360
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Narrative:
Data indicates a decrease in the rate of non fatal injuries among children <14. Unintentional injury remains an important area of focus for the Division of Injury and Violence Prevention. The Division maintains programs addressing child passenger safety, residential fire prevention, and leads a child fatality review process. In addition, the Division also maintains an injury surveillance system to determine the magnitude, causes, and risk factors associated with injury. The Division also maintains the violent death reporting system that collects information on violent deaths in South Carolina as part of the National Violent Death Reporting System. This system answers critical questions of when, where, and how violent deaths occur.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	670.1	601.7	515.5	460.4	460.4
Numerator	5656	5119	4487	4049	4049
Denominator	844090	850790	870430	879360	879360
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data reflect provisional estimates based on 2008 figures.

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2009.

Narrative:
The rate of non-fatal injuries due to motor vehicle crashes among those <14 has decreased substantially over the past several years. The Division of Injury and Violence Prevention (DIVP) continues work to address motor vehicle safety. Child Passenger Safety Instruction has been provided to 83 technicians. Eight 32-hour National Standardized Child Passenger Safety Training Classes have been conducted. Staff also have conducted eighteen child safety seat inspection events and continue to participate in outreach efforts to the Hispanic/Latino Community. In addition, DIVP staff has distributed 281 convertible car seats and 56 booster seats. DIVP also continues to provide child injury prevention education and technical assistance to communities and organizations across the state upon request and referral. Efforts to sustain core program activities including providing public education on the seatbelt and child restraint laws and best practices, increasing local capacity for child passenger safety through training of certified Child Passenger Safety Technicians, providing technical assistance and CPS program supplies to state and local partners, and leveraging resources and building partnerships at the state and local levels to increase CPS programs capacity statewide will continue.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3,080.3	2,931.1	2,773.4	2,766.2	100,000.0
Numerator	18660	17937	17204	17289	1
Denominator	605789	611950	620320	625020	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Information not yet available

Notes - 2007
Data from the birth file/vital records/ PHSIS are not available for 2007 at this time because the file has not been closed. We anticipate having the data by August 2009.

Narrative:
Data indicates the rate of non-fatal injuries due to motor vehicle crashes among youth aged 15-24 remains stable. Unintentional injury remains an important area of focus for the Division of Injury and Violence Prevention. The Division maintains programs addressing child passenger safety and also maintains an injury surveillance system to determine the magnitude, causes, and risk factors associated with injury, including those from motor vehicle crashes. Information gathered provides guidance in developing appropriate strategies for addressing this issue.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	42.7	47.2	52.8	53.2	56.9
Numerator	6116	6229	8199	8378	8983
Denominator	143376	131913	155330	157541	158000
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Numerator Data for chlamydia were obtained from Terri Stephens, Division of Epidemiology.

Denominator data from CDC Wonder:
http://wonder.cdc.gov/population-projections.html

Narrative:
Data indicates the rate of Chlamydia among women 15-19 has increased over the past 4 years. However, this is likely the results of more comprehensive reporting systems. Previously, Chlamydia was not reported by name therefore reporting was inconsistent. In addition, reporting is now obtained from lab data (which is more of a gold standard) and also includes electronic lab data from non-DHEC labs.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	12.4	12.9	16.3	16.0	16.4
Numerator	9288	9479	11824	11610	11863
Denominator	746169	734033	723460	723460	723460
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data for numerator are from Terri Stephens, Division of Epidemiology.

Denominator data is from CDC Wonder:
http://wonder.cdc.gov/population-projections.html

Narrative:
Data indicates the rate of Chlamydia among women 20-44 increased notably in 2006 and has remained stable. The increase was likely the result of more comprehensive reporting systems. Previously, Chlamydia was not reported by name therefore reporting was inconsistent. In addition, reporting is now obtained from lab data (which is more of a gold standard) and also includes electronic lab data from non-DHEC labs.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	56540	34190	18210	0	0	0	4140	0
Children 1 through 4	257055	138679	98905	1125	6233	0	12113	0
Children 5 through 9	259943	172626	79178	0	860	0	7279	0
Children 10 through 14	296883	194426	84303	1182	3894	0	13078	0
Children 15 through 19	325336	199639	110030	989	5075	0	9603	0
Children 20 through 24	308436	214818	83076	2862	6314	0	1366	0
Children 0 through 24	1504193	954378	473702	6158	22376	0	47579	0

Notes - 2011

Narrative:
Shifting population demographics can have a significant influence on program and service delivery. There have been no major swings in population demographics.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	54308	2232	0
Children 1 through 4	248236	8819	0
Children 5 through 9	252727	7216	0
Children 10 through 14	287913	8971	0
Children 15 through 19	318455	6879	0
Children 20 through 24	297468	10968	0
Children 0 through 24	1459107	45085	0

Notes - 2011

Narrative:
Shifting population demographics can have a significant influence on program and service delivery. The number of births to women of Hispanic ethnicity remained stable from 2007-2008.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	108	45	57	1	0	0	4	1
Women 15 through 17	2519	1136	1288	11	5	0	77	2
Women 18 through 19	5790	2995	2627	26	14	4	120	4
Women 20 through 34	47921	31261	15108	198	710	51	516	77
Women 35 or older	6737	4932	1512	26	184	6	66	11
Women of all ages	63075	40369	20592	262	913	61	783	95

Notes - 2011

Narrative:
Overall the number of live births increased slightly from 62,933 in 2007. There were fewer births among teens <15 than in the previous year. There was an increase in the number of births among women 35 and older.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	91	17	0
Women 15 through 17	2270	249	0
Women 18 through 19	5298	490	2
Women 20 through 34	42988	4910	23
Women 35 or older	6168	563	6
Women of all ages	56815	6229	31

Notes - 2011

Narrative:
Overall there was no change in the number of births to women of Hispanic ethnicity. In there were fewer births in each age category except women 35 and older, of which there was an increase in the number of births.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	505	236	228	3	2	1	9	26
Children 1 through 4	70	47	20	0	0	0	1	2
Children 5 through 9	37	18	17	0	1	0	0	1
Children 10 through 14	61	38	22	0	0	0	0	1
Children 15 through 19	229	133	89	3	0	1	0	3
Children 20 through 24	362	212	144	0	2	0	0	4
Children 0 through 24	1264	684	520	6	5	2	10	37

Notes - 2011

Narrative:
The infant mortality rate in 2008 is the lowest in the past 20 years. The number of deaths decreased in every age category with the exception of children 15-19. There was an increase in deaths among this age group.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	432	46	27
Children 1 through 4	58	9	3
Children 5 through 9	36	0	1
Children 10 through 14	60	1	0
Children 15 through 19	210	13	3
Children 20 through 24	331	22	9
Children 0 through 24	1127	91	43

Notes - 2011

Narrative:
There was a slight increase in the number of infant deaths from the previous year. There was also an increase in deaths among children 1-4 and 20-24. Deaths in other age categories remained constant.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1200500	764370	411030	0	0	0	0	25100	2008
Percent in household headed by single parent	34.0	0.0	0.0	0.0	0.0	0.0	0.0	34.0	2009
Percent in TANF (Grant) families	3.0	0.0	0.0	0.0	0.0	0.0	0.0	3.0	2009
Number enrolled in Medicaid	519072	0	0	0	0	0	0	519072	2009
Number enrolled in SCHIP	55405	0	0	0	0	0	0	55405	2007
Number living in foster home care	5367	0	0	0	0	0	0	5367	2009
Number enrolled in food stamp program	687508	0	0	0	0	0	0	687508	2009
Number enrolled in WIC	224518	116984	104171	583	1965	311	0	504	2008
Rate (per 100,000) of juvenile crime arrests	106.2	0.0	0.0	0.0	0.0	0.0	0.0	106.2	2008
Percentage of high school drop-outs (grade 9 through 12)	39.0	0.0	0.0	0.0	0.0	0.0	0.0	39.0	2008

Notes - 2011
total enrollment - not just children

Narrative:

As the state economy continues to struggle, the need for public services has increased substantially. Medicaid has seen significant expansions with the largest category being children. SCHIP enrollment continues to move foreword. Increases in the WIC caseload have also been noted with more and more women and children qualifying for services. High school drop out rates remains a challenge with a significant proportion of students not obtaining a high school degree.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1124890	75610	0	2008
Percent in household headed by single parent	0.0	0.0	34.0	2009
Percent in TANF (Grant) families	0.0	0.0	3.0	2009
Number enrolled in Medicaid	0	0	519072	2009
Number enrolled in SCHIP	0	0	55405	2007
Number living in foster home care	0	0	5367	2009
Number enrolled in food stamp program	0	0	687508	2009
Number enrolled in WIC	192149	32466	504	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	106.2	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	39.0	2008

Notes - 2011
total enrollment - not just children

Narrative:
Obtaining these services can be challenging for those of Hispanic ethnicity. Data indicating Ethnicity is not as readily available as indicated by the large amount of missing data in this form. However, those of Hispanic ethnicity face similar challenges with a decreasing state economy and fewer services available.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	30000
Living in urban areas	278880
Living in rural areas	921650
Living in frontier areas	0
Total - all children 0 through 19	1200530

Notes - 2011
Estimation of 10% of kids living in urban counties

Narrative:
South Carolina is primarily a poor rural state. Approximately 70% of the State resides in urban commuting areas, 20% in large rural areas, and 10% reside in small rural areas. Rural geography poses many challenges for obtaining access to needed health services. Rural populations often reside in medical professional shortage areas, are uninsured or underinsured and travel further to obtain care. This can be particularly difficult for children with special needs residing in rural areas with limited access to pediatric sub-specialty care.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4461770.0
Percent Below: 50% of poverty	5.4
100% of poverty	14.0
200% of poverty	30.9

Notes - 2011

Narrative:
Approximately one in five children and adolescents under the age of 19 live in homes currently under the federal poverty line, with values ranging from 14%-50% by County. Moreover, the unemployment rate in South Carolina has reached 12.6% and is among the highest in the country further indicating troublesome trends related to poverty. Rural minorities are disproportionately represented in poverty in South Carolina.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1187869.0
Percent Below: 50% of poverty	7.9
100% of poverty	18.8
200% of poverty	43.3

Notes - 2011

Narrative:
Approximately one in five children and adolescents under the age of 19 live in homes currently under the federal poverty line, with values ranging from 14%-50% by County. Moreover, the unemployment rate in South Carolina has reached 12.6% and is among the highest in the country further indicating troublesome trends related to poverty. Rural minorities are disproportionately represented in poverty in South Carolina.

F. Other Program Activities

South Carolina has been fortunate to receive an environmental public health tracking grant (EPHT) from the Center's for Disease Control and Prevention (CDC). This grant is designed to provide policy makers and the general public integrated public health and environmental data. Two specific areas of MCH will be incorporated into the grant and includes Birth Defects Surveillance and Lead Surveillance data. This will allow MCH to expand the avenues in which we make surveillance data available to the public and improve data integration with other public health and environmental programs.

G. Technical Assistance

MCH has identified three key areas of technical assistance 1) Program planning and formal evaluation; 2) expanding existing staffs knowledge, skills, and abilities related to data analysis and program evaluation; 3) effective policy and advocacy for MCH populations.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11526057	12037520	11407861		11406437	
2. Unobligated Balance *(Line2, Form 2)*	17342	2718	148046		199538	
3. State Funds *(Line3, Form 2)*	16140604	11087537	15506362		11181420	
4. Local MCH Funds *(Line4, Form 2)*	13793076	10258566	9456549		6514290	
5. Other Funds *(Line5, Form 2)*	179748	37144551	35004371		32774592	
6. Program Income *(Line6, Form 2)*	15247364	13312046	16087306		16133189	
7. Subtotal	56904191	83842938	87610495		78209466	
8. Other Federal Funds *(Line10, Form 2)*	102257087	107593152	58548563		109735712	
9. Total *(Line11, Form 2)*	159161278	191436090	146159058		187945178	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	3092196	869695	1333185		811259	
b. Infants < 1 year old	3662194	2969811	3899904		2770267	

c. Children 1 to 22 years old	10795155	5025101	4972948		4687461	
d. Children with Special Healthcare Needs	14184674	12136311	13058671		11320863	
e. Others	22976105	60984177	62621182		56886603	
f. Administration	2193867	1857843	1724605		1733013	
g. SUBTOTAL	56904191	83842938	87610495		78209466	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	121174		161974		107922	
c. CISS	287755		15226		0	
d. Abstinence Education	670435		888324		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	86535311		43844417		101862845	
h. AIDS	892468		890987		0	
i. CDC	544383		380326		377857	
j. Education	6447861		5860209		0	
k. Other						
EHDI Tracking	0		0		123856	
Family Planning	5907530		6117930		6941795	
Nurse Fam Ptnrshp	0		0		109769	
Univ Nwbrn Hearing	0		0		211668	
Afr Amer Risk Reduct	659769		220669		0	
Infant Hlth PRAMS	0		168501		0	
Dept Ed Social Work	19189		0		0	
PRAMS	171212		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	8605097	11908704	4704287		11108549	
II. Enabling Services	47862035	70614223	82862961		65869599	
III. Population-Based Services	412056	753452	41531		702827	
IV. Infrastructure Building Services	25003	566559	1716		528491	
V. Federal-State Title V Block Grant Partnership Total	56904191	83842938	87610495		78209466	

A. Expenditures

Variability in budget reporting from year to year is becoming more evident. The primary source of the variability stems from ongoing challenges in defining and measuring Title V program activities and individuals served. There have been significant internal changes in defining and reporting the number of individuals served under Title V (Form 7). In previous years we have been able to define and report these numbers from well established internal client databases. However, there has been a substantial movement away from the direct services, which provided the basis on which these numbers were predicated. Defining the Title V population in the context of population based/infrastructure building services has been a challenge. For the most part, available program information regarding WIC participation, and program service estimates for CSHCN have been used to establish the populations served by Title V. However, this does not capture the full essence of Title V program activities.

The ongoing variability in defining the Title V population served also impacts budgeting information provided. Reported expenditures for pregnant women, infants, children, CSHCN, others, and administration are only as stable as the Title V population served information contained in Form 7. Variability in defining Title V population served creates variability in budget reporting from year to year. Moreover, existing cost-accounting methods and data systems are designed to capture program activities and have difficulty capturing effort towards population based/infrastructure building services. This is a potential source of bias in budget reporting and could explain the disparity related to expenditures on direct/enabling services compared to population based/infrastructure building services.

Over the next year special attention will be given to establishing a reasonable, reliable definition related to the number of individuals served under Title V with a clear, consistent data source. In addition, efforts will be made to examine the existing cost-accounting system to determine the extent to which population based/infrastructure building efforts and program activities can be more clearly captured. As HRSA Title V program expectations continue to shift towards population based/infrastructure building activities, clearer definitions of acceptable Title V population definitions is warranted.

B. Budget

As required by OBRA '89, South Carolina allocates a minimum of 30% of Federal Block Grant Funds for preventive and primary care services to children, and a minimum of 30% is allocated to children with special health care needs that are part of a system of services which promotes family-centered, community based coordinated care. As noted in Form 2, the 41% of the federal allocation was spent on preventive and primary care services for children, 33.2% on services for children with special health care needs, and 9% of Title V administrative cost. State and local funds include several programs and initiatives directly and indirectly related to MCH populations not directly funded under Title V. In some instances local services are able to direct program revenue which provides additional funding to support ongoing program operations.

The Agency uses the Personnel Cost Accounting System (PCAS) to document personnel expenses. Annually MCH staff review PCAS codes and realign with the levels of the MCH pyramid. As noted in the previous section, PCAS has difficulty capturing program activities related to population based/infrastructure building activities. The Bureau and the Agency will continue to work toward determining the best means of capturing program activities and effort down the MCH pyramid as program focus continues to shift.

The DHEC Bureau of Maternal and Child Health based the 1989 Maintenance of Effort on the state expenditure of $8,425,466. FY 1994 was the first year the direct state appropriation for MCH services to the Bureau dropped below the 1989 effort level. We requested that the 1989 baseline

be amended to include expenditures for family planning services. The FY 1989 Family Planning expenditures were $3,020,500. The State of South Carolina documents a total of $11,445,966 as the 1989 baseline against which future effort is measured. This combines the 1989 state expenditures for maternal and child health services with the Family Planning expenditures.
For FY 2011, state appropriations for organizational units under the direction of the state Maternal and Child Health Director are expected to be $11,181,420. We also identify Health Services Central Office state funded personnel costs in the amount of $419,923, as these staff is in MCH Divisions. The State of South Carolina exceeds the 1989 maintenance of effort requirement by $155,377.

Match: Title V matching requirement for the FY 2011 grant award of $11,406,437 is $8,554,828. We identify $8,554,828 of the state allocation in the Women and Children's Services, Children with Special Health Care Needs, and Research and Planning organizations as match.

Fiscal Management Procedures: The Bureau of Financial Management procedures can be provided upon request

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.